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Between Ourselves

Speaking on behalf of the nursing association in her native province, **Muriel E. Hunter** proudly points to the progress that the ***nurses of New Brunswick*** have made in working toward an increasingly high standard of education and service. Their inclusion of informed lay persons in some of their actively functioning committees is a long stride forward in achieving public understanding of the problems besetting the nursing profession. It is a pattern worthy of emulation.

It is doubtful if any nurse knows New Brunswick's needs more thoroughly than Miss Hunter. As director of public health nursing service for the province for almost ten years, she has travelled the seldom-frequented by-roads with her nurses. Even before she entered the school of nursing of the Montreal General Hospital for her training, Miss Hunter had become familiar with the educational problems of her province through her experience in teaching. All of these factors have enriched the qualities of leadership which she has brought to the presidency of the N.B.A.R.N. during the past year.

* * *

The dominant note of this issue is on ***tuberculosis.*** Despite the fact that the cause of this disease, the tubercle bacillus, was discovered by Robert Koch as long ago as 1882, despite the remarkable advances that have been made in prevention and treatment during recent decades, tuberculosis still remains a stealthy invader. We are grateful to *Industrial Medicine and Surgery* for their kind permission to present **Dr. L. Brahdy's** informative discussion of the problem that still exists in protecting the nurses in our hospitals from this infection.

It is of interest to note that at the annual meeting of the Canadian Tuberculosis Association held last spring three resolutions were devoted to the problems of rehabilitation. **Joan M. R. Ainsworth's** article discusses ways and means of making such a program truly effective. Knowing and utilizing every community resource to promote such a rehabilitation program is well within the sphere of every nurse. Perhaps **E. A. Sebire** has put her finger on the weak spot in the nurse's preparation that would fit her more adequately to participate in every phase of the tuberculosis program. "When a true diagnosis of tuberculosis is made, the patient is transferred to a sanatorium and the average nurse's interest wanes." Mrs. Sebire proposes a very practical method by which the nurse's knowledge and interest may be rekindled.

We must be certain that our progress in helping to control tuberculosis up to the present time does not blind us to the needs that must still be met. We need more enthusiasm for the work that still must be done, more of the spirit and courage of the pioneers in tuberculosis nursing who were willing to undertake what must have seemed at the time a hopeless task. Tuberculosis has been partially defeated. Let us recognize the importance of working steadfastly toward the goal of a world free from this disease.

* * *

Within recent weeks the *Journal's* application for membership in the ***Canadian Circulations Audit Board*** necessitated a detailed study of the types of paid circulation currently being carried. Some interesting and revealing statistics have been secured. We now know, for example, that on the basis of the number of subscribers as of June, 1951, a total of 8,841 graduate nurses in Canada were on our mailing list. When it is revealed that 2,731 of those lived in Ontario, 2,332 in Alberta, and 951 in New Brunswick, it leaves pretty slim pickings — 2,827 graduates — to be divided among the remaining seven provinces. The total membership of the Canadian Nurses' Association as at December 31, 1950, was 30,333. On that basis, only 29.1 per cent of the membership actively support their own nursing journal. Is it any wonder, really, that national advertisers raise a figurative eyebrow when we claim that the nurses of Canada do believe in, do read this periodical? True, there were 2,025 student nurses subscribing at that date. There were 307 copies addressed to hospitals, 47 copies to libraries, 56 copies to public health units and V.O.N. branches, etc., for a grand total of 12,189 paid subscribers. When told how the circulation has increased by 100 per cent in the past seven years, many nurses exclaim: "Isn't that wonderful!" Maybe so but, when the above figures are considered, it is rather a sorry confession of lack of support, isn't it? — excepting in Alberta and New Brunswick!

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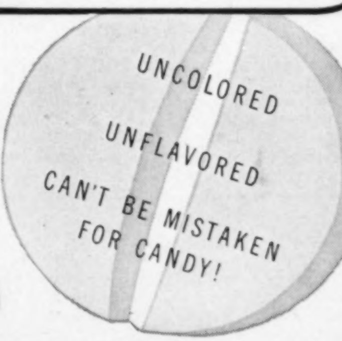
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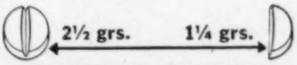
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New Products

Edited by PROFESSOR F. N. HUGHES

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THIOMERIN

Manufacturer—John Wyeth & Bro. (Canada) Limited, Walkerville, Ont.

Description—Mercaptomerin Sodium is an organic mercurial compound, a white amorphous powder readily soluble in water.

Indications—Edema due to heart, kidney, or liver disease and generally whenever mercurial diuretic therapy is indicated. Response to subcutaneous injection is essentially that of equivalent intravenous doses of other mercurial diuretics.

Administration—0.5 cc. to 2 cc. injected subcutaneously and repeated in accordance with the requirements of the individual patient.

How Supplied—In multiple dose vial containing 1.4 gm. of powder with 10-cc. ampoule sterile water. 10 cc. solution will contain 0.040 gm. mercury per cc.

VASOXYL and VASOXYL-P

Manufacturer—Burroughs Wellcome & Co., Montreal.

Description—Each 1-cc. ampoule contains 20 mgm. Vasoxyl (Methoxamine Hydrochloride), a new synthetic vasoconstrictor. Each 1 cc. of Vasoxyl-P contains Vasoxyl 15 mg. and Procaine HCl 1%.

Indications—During operative procedures to maintain blood pressure or restore it to normal levels. Especially useful to counteract fall in blood pressure following spinal anesthetic or with cyclopropane anesthesia.

Administration—Intramuscularly. Vasoxyl-P may also be used intradermally to produce local analgesia at site of spinal puncture. *Not* intended for intrathecal administration or as a spinal anesthetic.

VARIDASE

Manufacturer—Lederle Laboratories Division, North American Cyanamid Ltd., Montreal.

Description—Each vial contains 100,000 units of Streptokinase and 25,000 units Streptodornase.

Indications—To dissolve clotted blood, viscous pus, and fibrinous accumulations. Useful in surgery and in skin grafting by aiding in removal of dead tissue. In treatment of hemothorax, hematoma, empyema, osteomyelitis, draining sinuses, tuberculous abscesses, infected wounds or ulcers, etc.

OBEDRIN

Manufacturer—S. E. Massengill Co. Canadian distributors: Professional Drug Services (Winter Laboratories), 341 Bloor St. W., Toronto 5.

Description—Each grooved tablet contains—

Semoxydrine hydrochloride	5 mg.	Thiamine hydrochloride	0.5 mg.
Pentobarbital sodium	20 mg.	Riboflavin	1.0 mg.
Ascorbic acid	100 mg.	Niacinamide	5.0 mg.

Indications—To supply balanced dietary supplement and to help control craving for food in patients on a restricted reducing diet.

P.K.Z.

Manufacturer—Rexall Drug Co. Ltd., Toronto.

Description—Each fluid ounce contains: Pectin, N.F. 4½ gr., Kaolin 90 gr., Zinc sulfocarbolate, N.F. 1⅛ gr. in a pleasantly flavored vehicle.

Indications—An intestinal adsorbent and demulcent for the relief of simple diarrhea, dysentery, and other inflammatory conditions of the gastrointestinal tract.

Administration—Orally. Adults—2 tablespoonfuls, repeated every 3 hours if needed. Children—5 to 12 yrs. one-half adult dose. For children under 5, give only as physician directs.

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Yeast concentrate	2 gr.	Niacinamide	5 mgm.
Thiamin chloride	1 mgm.	Alcohol	12½% by volume

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Indications—Where iron and vitamin tonic is indicated.

SUDROMA Dental Pack

Manufacturer—Charles E. Frosst & Co., Montreal.

Description—A non-toxic, therapeutic, periodontal preparation containing water-soluble derivatives of Chlorophyll "a."

Indications—For deodorization and acceleration of healing in inflammation of gingival and oral mucosa; for Vincent's infection; and for packing of sockets following extractions.

Administration—Apply to allow direct contact for ½ hour. Repeat until condition corrected.

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Manufacturer—Charles E. Frosst & Co., Montreal.

Description—Natural water-soluble derivatives of Chlorophyll "a" in a hydrophilic ointment base.

Indications—For deodorization and treatment of chronic ulcers, suppurative lesions, dermatoses, osteomyelitis, and burns.

Administration—Apply freely as a dressing and bandage if desired.

BURN OINTMENT

Manufacturer—Rexall Drug Co. Ltd., Toronto.

Description—Contains: Lauryl pyridinium chloride (quarternary type antiseptic), Benzocaine 3%, Allantoin and urea (Carbamide) in a water-soluble base.

Indications—An antiseptic, anesthetic, and healing dressing for burns (including sunburn), scalds, insect bites, and skin irritations.

Administration—For topical application. When possible, cleanse area with soap and water and apply ointment liberally over entire surface of burn. In severe cases cover with a loose bandage. The ointment may be readily removed with water.

VENTRILEX KAPSEALS

Manufacturer—Parke, Davis & Co. Ltd., Walkerville, Ont.

Description—The recognized antianemic principles present in crystalline vitamin B_{12}, with concentrated stomach tissue, folic acid, iron, liver concentrate and vitamin C in a red Kapseal with a blue band. Each Kapseal contains: Crystalline Vitamin B_{12}, 10 mgm.; concentrated extract of stomach, 0.3 gm.; liver concentrate, 0.1 gm.; folic acid, 2 mgm.; ferrous sulphate, 0.2 gm.; and ascorbic acid, 50 mgm.

Indications—A convenient oral form of treatment for many types of anemia, especially those of a combined nature.

The American Cemetery Association, in Columbus, Ohio, has taken a negative approach to atomic attacks and offers the advice we are reproducing below. There's truth in what they say. Even though you get a chortle out of their advice, think over what they say, particularly the end result:

As soon as the bombs start dropping — run like heck. It won't do you any good but it keeps your mind off more important things.

If you find an unexploded bomb, always pick it up and shake it. The firing pin is probably stuck and bombs in that condition are a constant source of danger.

Always under any circumstances, get excited and shout. It will add to the confusion and scare the devil out of little kids.

Go to the nearest phone and start calling your friends. Someone might want to call the fire department but they will be busy and appreciate not being called.

Always eat heavily of garlic and limburger cheese and drink strong wine before entering a shelter. This makes you a bit unpopular but it is surprising how much more room you get.

Knock those down in charge if they start telling you what to do. They always save the best seats for themselves anyway.

If you should be the victim of a direct hit, don't let it upset you — don't under any circumstances fly to pieces. Just lie down and relax — you're dead ! —*The Alcan Ingot*

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MEAT in the diet of premature infants *

By *Thomas R. C. Sisson, M.D., Anne F. Emmel, M.D., and Lloyd J. Filer, Jr., Ph.D.,* Rochester, N.Y.

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* This study is another in the extensive research program instituted by Swift's for Swift's Meats for Babies. The program is designed to provide the medical profession with as complete a fund of clinical information as possible on the effects of meat in infants' diets. *If you would like a reprint of the entire article as it appeared in the January issue of* Pediatrics, *write to Swift Canadian Co. Limited, Nutrition Division, Toronto 9, Ontario.*

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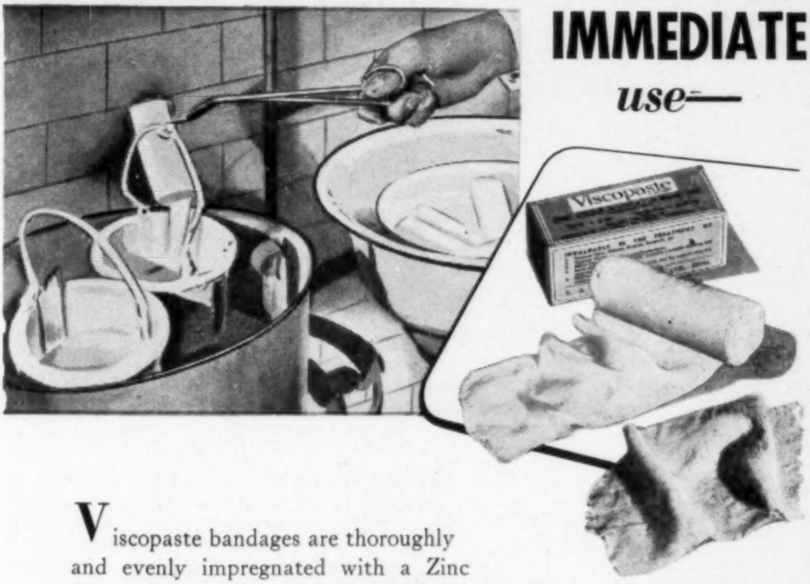

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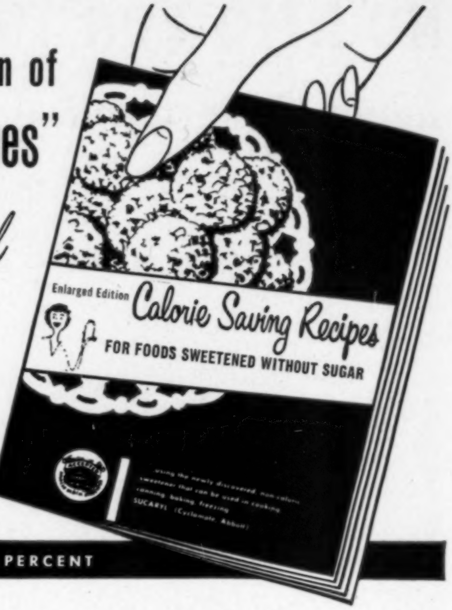
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CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SEVEN *NUMBER ELEVEN*

MONTREAL, NOVEMBER, 1951

Progress in New Brunswick

Average reading time — 4 min. 6 sec.

ONCE AGAIN we come to you from New Brunswick, one of those Maritime provinces where, in the past, history has been made.

We are told that this time the New Brunswick nursing association made history when, at its annual meeting in 1949, the members voted unanimously to include a subscription to *The Canadian Nurse* in their annual fee, which was increased at that time to ten dollars. Since January, 1950, every active paid-up member in New Brunswick receives the *Journal* regularly, and in 1950 we had 1,226 members. We earnestly hope that every member reads the *Journal*, as one means of keeping up to date not only on nursing affairs but on many new aspects of medicine as well.

The first preliminary examinations in our province were written in June, 1950, and were our first registration examinations to be written in both English and French.

The Educational Policy Committee is one of our most active committees and represents not only nursing but other professions and interests as well, including representatives from two universities, the Medical and Hospital Associations, the provincial Departments of Health and Education, the radio, press, and citizens at large. Meetings of the nurse members of this committee are held from time to time as necessary. In December, 1950, a meeting of the entire committee was held in Fredericton. Although nothing concrete developed from this meeting, the nurse members who attended felt that those present from outside our profession were intensely interested and gained considerable insight into many of the difficulties confronting the nursing profession. Discussed at this meeting were schools of nursing with respect to hospital boards, financing and administration, present and future entrance requirements; the practical nurse situation; present university education, and changes in nursing education.

The Educational Policy Committee is now working on a project in nursing education which would seem to meet the needs of New Brunswick.

A combination of circumstances made it advisable to move the provincial office from Saint John to Fredericton. This was accomplished on May 1, 1951, and the office is now situated at 380 Queen Street in Fredericton.

A project on which our association had been working for nearly three years reached fulfilment on May 15 of this year, when a school of nursing adviser was secured. This project, in its talking stage, started as a Maritime venture. Nova Scotia decided to try to finance one of its own. It then became a joint project with Prince Edward Island. They have since made other arrangements and New Brunswick decided to carry on alone. The project is being financed through the federal grants and the N.B.A.R.N. is extremely grateful to the Department of Health and Social Services for this help.

Assistance was given through federal grants to finance a refresher course for public health nurses of the province in June, 1951. This course dealt largely with maternal and child health programs and was put on by two members of the staff of the School for Graduate Nurses, McGill University, assisted by a pediatrician from Saint John. Plans are now being completed for an institute for supervisors and head nurses, late this fall.

During the past year, attention has been focussed on local chapters, of which there are now seven in the province. New by-laws have been drawn up, relating to chapters, and will be presented to the annual meeting in September. More emphasis is being placed on the fact that local chapters are professional organizations and not service clubs and that nursing should occupy a large place in their programs.

In March of this year the Fredericton Chapter put on a two-day institute on nursing affairs. On the second evening an open meeting was held in the ballroom of the Lord Beaverbrook Hotel and the program took the form of a panel discussion on nursing education, with particular reference to New Brunswick. Those taking part were the chief superintendent of education, the president of the N.B.A.R.N., the chief medical officer of the province, and the general secretary of the Canadian Nurses' Association. More than 200 written invitations were sent to doctors and hospital personnel, the university staff, Departments of Health and Education, and to all lay organizations in the city. Publicity was also given by radio and press. The attendance and interest was extremely gratifying.

The New Brunswick Association of Registered Nurses is trying very hard to interest the public in nursing, so that we may have understanding and help in these difficult days of misunderstanding and confusion. We have reason to hope that we are making progress in this direction.

MURIEL E. HUNTER
President,
New Brunswick Association
of Registered Nurses.

Nutrition

The nurse who takes the lead in creating a nutrition consciousness on the part of both the sick and well must first and foremost have a thorough grasp of the relationship of food to nutrition and the widespread influence of nutrition on the welfare of the country. In other words, she must be wholeheartedly convinced of the worthwhileness of effort aimed at arousing a nutrition consciousness.

Guiding families in the development of good food habits requires a knowledge of nutritional principles but equally essential is the ability to make practical suggestions for the application of this knowledge. The most effective work in changing food habits is not done by formal nutrition teaching but by making appropriate suggestions or asking pertinent questions at the "right" time. If a nurse, for instance, arrives at a home to find the vegetables much over-cooked, the undernourished child eating excess sweets, or the cod liver oil which was brought from school sitting on the window ledge in the kitchen, unused, she has excellent demonstration material at hand. —*Newfoundland Nursing Services Annual Report.*

Occupational Tuberculosis Among Nurses

LEOPOLD BRAHDY, M.D.

Average reading time — 13 min. 36 sec.

ONLY IN THE LAST 25 years have we become aware that tuberculosis is an occupational disease among medical students, nurses, interns, and other hospital personnel. The experience in all sections of the United States has confirmed the finding that the majority of student nurses who have no trace of tuberculosis on beginning training are infected before their graduation. This high incidence of infection occurs in general hospitals that do not have tuberculosis wards as well as in tuberculosis institutions. The consequence is that annually a number of nurses become ill with the disease. They must give up their work to spend several years under treatment at tuberculosis sanitaria. Even with the best of medical care, a few of them die each year, victims of a disease we know is preventable.

In 1928, a tuberculosis morbidity of 155 cases in 5,364 observation years was reported from the Ullevaal Hospital in Oslo, Norway.[1] Since then there have been numerous reports and among those in the last decade the most extensive is of a study in England which included 5,091 nurses. It gives a morbidity of 2.3 per cent per annum.[2] In a Canadian hospital, the annual incidence is reported as 1.7 per cent.[3] Trudeau Sanitarium found that, of the nurses affiliating there, 2.5 per cent developed tuberculosis during or after their affiliation.[4] At the University of Michigan Hospital about 2 per cent developed the disease.[5] A combined study of six Minneapolis general hospitals shows 1.3 per cent nurses developing tuberculosis during training or within one year after graduation.[6] This incidence in Minneapolis is low compared with other hospitals but the authors find it is greater than that of young women in other occupations. In Boston City Hospital there was an *annual* incidence of 0.93 per cent.[7] A report from the Metropolitan Hospital in New York City, on a five-year study, states that 3.4 per cent of the student nurses developed tuberculosis.[8] At Kings County Hospital in Brooklyn, there is an overall incidence of 6.3 per cent.[9] In the Philadelphia General Hospital there was an annual morbidity of 4.8 per cent.[10]

Among physicians and medical students of Minnesota University in the classes of 1919-32, 3.9 per cent developed tuberculosis while in medical school and 3.3 per cent after graduation — a total of over 7 per cent. In the identical period, among students of law and recent law graduates of the same university only 1.3 per cent developed tuberculosis.[11] Among medical students at Northwestern University from 1936 to 1940, 2.7 per cent developed tuberculosis before graduation.[12]

A cooperative study under the guidance of the U.S. Public Health Service was made in a number of hospitals which included more than 20,000 student nurses. A summary of the recent literature with extensive bibliography by Eleanor C. Connolly has been published.[13] A table showing the incidence found by many observers is included in the Report of the Prophit Survey.[2]

Student nurses are a select, young, and healthy group and the majority of them are tuberculin negative when first examined. They are re-examined periodically so that the time of infection and of onset of the disease can be determined with some accuracy. The spread and development of tuberculosis thus is observed under almost laboratory conditions. Medical students and interns more recently have received the benefit of thorough periodic examinations. There is no longer any doubt of the occupational hazard in these groups. Other hospital

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Dr. Brahdy lives in New York City.

employees have been observed less meticulously; occupational tuberculosis afflicts them, too, though not so frequently. Graduate nurses and supervisors, social workers, ambulance drivers, technicians, ward clerks, elevator operators, porters, administrators, and everyone else in a hospital who has contact with the patients or the laboratories may be subject to the hazard of occupational tuberculosis. The extent of the hazard for them has not been accurately determined.

In the last two decades many states have extended their workmen's compensation laws to cover hospital employees who acquire tuberculosis because of their work. Prior to the extension of workmen's compensation coverage to them, each employee and his family carried the financial burden of his disability and his medical care. Compensation coverage shifts the major share of the cost to the employing hospital. The total of the financial burden is not changed by shifting it from the employees to the employer; it is only concentrated. Hospitals usually insure themselves against workmen's compensation costs. Paying a premium to an insurance company should not obscure the fact that the hospital carries the expense. Paying a premium for insurance does not decrease the financial burden. Because of the tuberculosis morbidity among their personnel the annual premium of hospitals has risen steadily and it is now a serious burden which can be reduced only by reducing the incidence of occupational tuberculosis.

Besides the direct compensation expense to the hospitals, there is the waste in losing a skilled worker and hiring and training a new employee; there is the slump in morale throughout the institution when one member of the staff is stricken with so serious an occupational disability. Also there are remote adverse effects which cannot be measured or estimated. Among these is the effect on prospective candidates for nursing schools when gossip of tuberculosis among nurses spreads among high school girls and their mothers. This gossip is usually fantastic exaggeration but, because it has a core of truth, it is difficult to correct. No one can guess how many girls have changed their choice from useful nursing careers to fields in which they are less needed because a nurse they know returned to their home town with tuberculosis acquired in her hospital. A serious loss accrues to the employee because compensation gives him only part of his wages during his illness. There is, of course, no compensation for the employee's misery and for the boredom of the months and years spent recovering from the disease, nor for the blasted hopes and sometimes blighted lives.

I emphasize the cost to the hospital to make one fact clear: it is sound economy for hospitals to invest in the prevention of occupational tuberculosis among their personnel. Even if not legally obligated, every hospital should provide medical care and sick pay for its employees disabled by tuberculosis owing to their duties in the hospital.

Periodic examination of personnel will uncover the disease in the early stage when it is amenable to treatment. An equally important reason for periodic examination of personnel is the protection of the hospital patients. Early discovery of every case of tuberculosis in the personnel protects the hospital patients from the danger of being infected by their attendants. This is comparable to safeguarding patients from pyogenic infection in the operating room. An operating room infection is promptly manifest; therefore it elicits energetic and continuing action by the hospital staff to eliminate the danger of recurrence of the conditions which may cause infection. An infection of a patient with tuberculosis is not known until months or years later. A specific case cannot be traced with any certainty to infection while in the hospital. Nevertheless, there is little doubt of the danger for patients where nurses and other personnel are not periodically examined and it should elicit similar energetic sustained action.

More can be done than discovering the disease early in personnel; it can be prevented. The first step towards prevention of occupational tuberculosis is to uncover every case of communicable tuberculosis *among the patients.* That requires chest x-ray examination of every patient on admission. Only when both employees and patients have chest x-rays does the hospital break the vicious cycle: infection of personnel by patients with no one being aware that these patients have tuberculosis and infection of patients by the personnel who continue on duty for months before being aware that they themselves are ill with tuberculosis. The prevention of tuberculosis in the personnel is only one of the several reasons for admission chest x-rays. In the interest of the patients, admission chest x-rays should be done even if there were no occupational disease problem.

Some hospitals adhere to the archaic custom of not admitting patients with *known* tuberculosis. Admitting a patient known to have tuberculosis is a minor hazard compared to neglecting to uncover the unknown cases admitted to every general hospital. A hospital should admit known tuberculosis cases and search for more cases among the other admissions. The hospital for its own welfare, as well as to serve its community to the fullest extent, should have its own tuberculosis wards or rooms. A hospital can cope best with its own personnel problem if it has tuberculosis specialists on its staff and has nurses trained on tuberculosis wards.

Conducting roentgen examinations on personnel and patients will go far toward decreasing the occupational hazard. For its elimination, additional measures are required in tuberculosis wards or sections, involving techniques in handling the known tuberculosis patient. The most important of these measures are strictest cleanliness; special technique in handling sputa and everything which may have contact with sputum droplets in the air; dust control by chemical and mechanical means and by training personnel in dust prevention methods; air sterilization by irradiation or by chemicals or by ventilation or an effective combination of these three.

Tuberculosis vaccination of certain groups of nurses may prove to be helpful but when used alone it is of minimal value. The use of vaccination when the other measures are neglected is bound to result in failure in the long run. Tuberculosis vaccination should not be used for nurses unless combined with intensive use of all other methods. The easy parts of the "contagion technique," such as wearing masks and washing hands, are used in some institutions but these, likewise, without the simultaneous use of other procedures are of little value. In fact, half-measures create false security which increases the hazard of infection. Occupational tuberculosis continues because inadequate preventive methods are used while each institution postpones a thorough study of what combination of measures is suited to its particular conditions. There is, alas, no single miracle method or combination of methods suitable for every institution.

Hospitals are one of the great industries and large employers. Other industries have one or more occupational disease hazards which in most cases have been met successfully. Hospitals must use the proved methods of industrial medicine to combat their own occupational hazard. The primary step is for each hospital to study the conditions within its own walls and lay the groundwork for tuberculosis prevention. Personnel must have periodic examinations, including x-rays and tuberculin tests. All patients must have admission chest films and records must be kept, both of manifest tuberculosis and of tuberculin conversion in personnel. It must be ascertained when, where, and under what condition disease became manifest or infection occurred. When accurate records have been continued for a number of years they should be published. Though a score of leading hospitals have reported their experience, this is not enough. Hospitals in every locality, treating different segments of the population and drawing personnel from various sections, should publish their findings. Making available the observations under varying conditions prevailing in different hospitals is an important contribution toward elimination of this occupational disease. Several methods of control must be used and their effects watched. They must be modified and adapted to the conditions present in the institutions studied and ways of improving cannot be relegated to a nursing supervisor, or to a roentgenologist, or to a tuberculosis physician primarily interested in therapy. Their efforts, as well as others, are required but all should function under the supervision of a physician whose primary interest is to control this intramural epidemic. He must bring to the problem the viewpoint and attitude of an industrial physician for the hospital. This will take tact, time, energy, and money.

A few hospitals successfully have decreased or eliminated occupational tuberculosis. It can be done in every hospital but this requires each hospital to exert its efforts to that end. The hospital owes that duty to its employees, to its patients, and to those who support it.

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Be Doubly Careful

It has been estimated that about 28 per cent of all motor vehicle fatalities occur in the autumn. The proportion is somewhat higher than in summer, even though the volume of travel drops off. Several factors account for the higher toll of motor vehicle accidents and deaths in the autumn than in the summer. The major one is the reduced number of hours of daylight but also important is the number of holiday week-ends that occur, the many car-loads going to football games, and the poor weather. In suburban areas, wet leaves on the highways add appreciably to the hazard of skidding.

—M.L.I.C. *Statistical Bulletin*

At the beginning of the century, Canada was among the group of nations with the highest tuberculosis death rates. Today, this country has one of the lowest rates in the world. On the basis of the most recent statistics, only two countries—Denmark and the United States—have lower rates than Canada.

Nursing Opportunities in the Tuberculosis Control Program

AGNES CAMPBELL

Average reading time — 5 min. 12 sec.

"SUCH SERVICE as only a nurse can provide, before, during and after treatment, is the hope of tuberculosis control," declared Dr. G. J. Wherrett, executive director of the Canadian Tuberculosis Association, in discussing the prospects for the nursing profession in the field in which he is a driving force.

Dr. B. D. B. Layton, of the Department of National Health and Welfare, who administers certain aspects of the tuberculosis control grants related to Canada's National Health Program, expressed himself in full accord with Dr. Wherrett's opinion. In fact, he said, public health authorities are so fully aware of the role of the nurse in this work that much of the effort extended by the provinces to help fight tuberculosis is directed specifically toward the training of nursing staffs and nursing specialists.

Canada has stepped up her health drive on all fronts, under impetus of the plan to build up the nation's forces and facilities for coping with disease. Federal grants totalling several millions of dollars are being devoted exclusively to the attack to beat down tuberculosis.

Despite the considerable advances which had been made in Canada in this field in recent years, it was agreed that much more remained to be done before tuberculosis could be considered under adequate control.

The federal funds, all of which are aimed at building up and extending health facilities in the various provinces, are divided on the basis of $25,000 flat grants to each province, the balance divided 50 per cent on the basis of population and 50 per cent according to the average number of deaths from tuberculosis in each province (including those of Indian and Eskimos) in the years 1942 to 1946, inclusive. These moneys are expected to enable the provinces to extend areas of free treatment and to accelerate the drive to wipe out the disease.

It was realized, at the outset, that such an ambitious program would require enlargement of nursing staffs as well as more equipment and, most of all, more accommodation for care and cure. Consequently, there have opened up opportunities previously unavailable to the nursing profession. Today, the nurse is finding herself increasingly in demand in tuberculosis control work and every effort is being made to interest young women in this field and to equip them to play their full part in coping with this problem.

Not only is the financial backing of the program making possible improved training facilities for undergraduates as well as for post-graduate work, but it has enabled the provinces to launch projects which they have long needed but, until now, have been unable to afford. Tuberculosis control divisions in the provinces are being expanded, positions are opening up in sanatoria, laboratories require more assistance from those with nursing qualifications, and there are opportunities in connection with surveys and in the operation of clinics, as well as in the surgical departments of Canada's hospitals.

Survey of the projects, which have been approved under the National Health Program's tuberculosis control grant in the years during which these funds have been available, reveals the extent and variety of activities which have been initiated. Many of these have meant new positions for nurses in a number of situations.

In the foreword of the publication

Miss Campbell is superintendent of nurses at the Prince Albert (Sask.) Sanatorium.

"What You Want to Know About Nursing," which the Department of National Health and Welfare produced for the Canadian Nurses' Association, Dr. G. D. W. Cameron, Deputy Minister of National Health, reminds young women contemplating such a career that "there have been few periods in Canadian history when the need for nurses to care for the sick and to help provide protective services has been more acute than it is today." Pointing out that the tremendous expansion now taking place in Canada's public health services cannot achieve full effect unless the supply of properly trained nurses is adequate, Dr. Cameron expressed the hope that "Canada's young women will enter upon the honorable career of nursing."

While the Deputy Minister's message was addressed to all aspiring to follow the Nightingale tradition, it has special application in the field of tuberculosis control. As Dr. Wherrett has stated, the type of care which only a trained nurse can provide, before, during and after treatment is nowhere more needed. Statistics show that Canada is making steady progress in her fight against tuberculosis — more promising progress than in many other fields of health conservation and advancement. It is, therefore, only a policy of wisdom to reinforce our success and to bend every effort to the final eradication of this ailment which once took such a heavy toll.

In this endeavor, Canadian nurses will continue to make an important contribution. As has been seen, it is a growing field in which the possibilities for service as well as for personal satisfaction are unlimited.

For those with a preference for institutional work there is probably no more suitable position than that which opens up to the nurse in connection with the new sanatoria now building and expanding. If the nurse prefers change of environment and multiplicity of cases, few branches of her profession afford such opportunities as tuberculosis control, with its need to reach out to every section of the country and, eventually, to bring all within the scope of its diagnostic services. There are, also, many openings for those with a preference for clinic and administrative duties.

The growing professional status of the nurse bids fair to provide a just return to those who devote themselves to the field of tuberculosis nursing. Salaries and working conditions in this field are equally as good, now, as in other branches of the profession.

The demand for properly trained young women prepared to dedicate themselves to this type of nursing is unlimited. Canada is counting upon increasing numbers of earnest workers joining in the fight and sharing in an humanitarian task in which we are definitely forging ahead.

An Appeal to All Nurses

E. A. Sebire

It is amazing the great number of registered nurses who fear to enter the tuberculosis field of nursing. In many cases it is the actual fear of the disease itself that deters them. This is due mainly to the fact that tuberculosis is rarely dealt with on an adequate scale in a school of nursing. When a true diagnosis of tuberculosis is made, the patient is transferred to a sanatorium and the average nurse's interest wanes.

When the patient is in a sanatorium that is a different problem. Then you know with what disease you are contending and take precautions accordingly. Here, indeed, is a field that brings out the best nursing ability in every true nurse. There is absolutely

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Mrs. Sebire lives at Cedar Crest Cottage, Collins Bay, Ont.

no need to be afraid of tuberculosis once you know the rules and technique for handling it.

Tuberculosis is a pioneering field that should call out the best in our profession. There are not nearly enough nurses to staff these institutions, and sanatoria, above all, should be well staffed. There are several post-graduate courses available now, the salary has been increased, and working hours are so much better than in the past.

Most nurses who take the plunge into the tuberculosis field like it very much and the experience is invaluable. Every aspect of medicine comes into use with the tuberculosis patient — medical, surgical, communicable, psychiatric, social welfare and rehabilitation problems are all taken care of in a sanatorium. If a nurse is a good tubercolusis nurse there is no other field she need fear. This experience fits her for any emergency and helps her to become a health teacher for prevention as well as cure of tuberculosis.

This is an appeal to all nurses to show greater interest in the great fight against tuberculosis which takes such a toll every year. The introduction of mass x-rays and surveys of all our population is a wonderful step forward. If we all work hard together tuberculosis should soon be as extinct in our country as diphtheria and smallpox.

An Affiliation Course in Tuberculosis Nursing

D. Lawrence *and* L. Kelly

When the staff of the Vancouver Unit of the Division of Tuberculosis Control, together with the provincial tuberculosis nursing director, investigated the possibilities of reorganizing the affiliation course in tuberculosis for student nurses, the study was approached with the following points in mind:

1. An appraisal of the effectiveness of the program as it then stood.
2. Was there need for changes and improvements to conform to present-day standards of nursing education and requirements for tuberculosis nursing?
3. How might we provide a better integration of theory and clinical experience?

The workshop conference method was adopted for the study to provide opportunity for free discussion by all persons concerned with the affiliation course. In this project we had the whole-hearted interest and cooperative support of representatives of all the departments in which the students are given experience. Supervisors, head nurses, and assistant head nurses attended all the sessions. Under the guidance of the provincial nursing director and the nursing instructor seven workshop sessions were held.

The following objectives for the affiliation course in tuberculosis nursing were approved by the group. Now each student is given a copy:

1. To stimulate interest in tuberculosis nursing through a realization of the scope in this branch of nursing in its broadest application.
2. To arouse a sense of responsibility toward the tuberculosis program and to encourage acceptance of this responsibility as a professional nurse and citizen. To help the student see the relation of the nursing service to the program as a whole and the need for public participation and support.
3. To develop understanding and ability in tuberculosis nursing in order to enable the student to give a high quality of

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Miss Lawrence and Mrs. Kelly were senior staff members in the Vancouver Unit of the Division of Tuberculosis Control when this material was prepared.

nursing care for the welfare of the patient in the broadest sense — procedures, nursing skills, approach to patient problems, teaching.

4. To help the student protect her own health and to avoid unnecessary infection through knowledge of the disease and proper technique standards.

5. To stimulate interest, ability, and incentive for health teaching in its broadest application — to patients, visitors, auxiliary personnel.

With these objectives before us, each department analyzed its resources to find out exactly what it had to offer the student in the way of learning experiences. Then, together, we studied the overall picture of the students' affiliation and selected those experiences which we felt most valuable to them in their short stay in each department. A master list of conditions, the nursing care of which is available to students in this Unit, was drawn up. Programs of experience in the various departments were prepared in the form of experience records to act as a guide to the student in ensuring a fully rounded affiliation and as a guide to the heads of departments in planning assignments to meet the students' needs. Lectures were planned to fall completely within their first week in the Unit, thus giving the students a background of knowledge prior to their clinical experience and leaving their practice period free from the interruption of formal lectures.

The affiliating groups continue to come to the Unit in the two groups, one week apart, which means a repetition of the complete series of lectures in the second week. The cooperation of the lecturers in making this possible is, indeed, gratifying. It was necessary for us to have a lecture-study room exclusively for our use in order to carry out such a plan and this has been arranged by combining our library and classroom facilities.

The brief five-week affiliation period is divided as follows:

1. *One week* in the classroom, during which time the students are given a series of 24 lectures and have their orientation to the wards as a group.
2. *Two to three days* in the diagnostic and survey clinics.
3. *Two to three days* with the public health nurses in the city.
4. *Two weeks* on a general ward.
5. *One week* on a surgical ward.

The modified block plan was carried out for a six-month trial period and then reviewed. We feel that it has been an improvement over the former method of distributing lectures throughout the five-week period in that it has given the students a more confident approach to the practice of tuberculosis nursing through a better preparation.

The use of the experience records has given the students greater incentive to evaluate their affiliation and to accept responsibility for making it as profitable as possible.

The fact that they are not called from the departments for classes gives the head of the service a better chance to carry out planned group teaching and avoid time-consuming repetition.

Having the students' experience unbroken by classes gives the supervisor a better opportunity to become acquainted with the student and allows for gradual delegation of responsibility. The students' performance may then be evaluated more fairly.

Implementation of the modified block plan has shown the need for minor adjustments which have been dealt with through further group meetings. However, we feel it is a very promising method for affiliation of students in tuberculosis nursing.

The revised course was put into effect with comparative ease due to the opportunity for all staff members concerned to participate in the analysis and planning through the work conference sessions.

This method of dealing with staff problems and projects is extremely effective in promoting the understanding and cooperation so essential for successful application of plans and progressive development. We wish to express appreciation to the Canadian Nurses' Association for the program of workshops initiated at the biennial conventions.

MASTER LIST OF CONDITIONS FOR STUDENTS' EXPERIENCE

General Wards

Always available — Nursing care of:
Minimal disease; moderately advanced disease; far advanced disease; rest with graded exercise; pneumothorax; pneumoperitoneum; bronchoscopy; phrenic operations; convalescent thoracoplasty; complication of diabetes; complication of some form of extrapulmonary tuberculosis.

Often available — Nursing care of:
Complication of psychiatric problems. Complication of pregnancy (always available to ⅓ of total students). Extrapulmonary tuberculosis involving larynx and pharynx; peritonitis; tongue; kidney; spine; hip. Convalescent resection surgery.

Surgical Ward

Always available—Nursing care of:
Pneumonectomy; lobectomy. Thoracoplasty: posterior, Schede's. Monaldi suctions: prethoracoplasty, post-thoracoplasty. Phrenic surgery (following resection surgery only). Pleural operations: closed pneumolysis; bronchoscopy. Drainage: closed, open.

Sometimes available — Nursing care of:
Segmental resection. Thoracoplasty: anterior, anterolateral, revision. Extrapleural relaxation therapy: pneumothorax, plastic ball. Pleural operations: open pneumolysis, insertion of catheter for closed drainage, rib resection for open drainage.

PROCEDURE RECORD

Division of Tuberculosis Control

Name

Graduating Class

School of Nursing

Date of Affiliation

Procedure	*Class or Demonstration*	*A satisfactory demonstration by student (Initialled by R.N.)*	*Procedure carried out— (No. of times up to four)*	*Observed only (No. of times up to four)*
A. Chest Clinics				
1. *Survey Clinic*				
Explanation of function				
Inspection of films by Dr.				
Tuberculin testing				
Mantoux				
Vollmer				
Instruction to parents re skin tests				
B.C.G. Vaccination				
2. *Diagnostic Clinic*				
Explanation of function				
Admission of new patients				
Admission of old patients				
Routine procedure for examinations				
Miners' examinations				
Reading of films				
Method of receiving report				
Signing of application				
Discharge interviews				
Record system				
Method of reporting to PHN				
Taking of stomach washings				
Lipiodol injections for bronchograms				

Procedure	*Class or Demonstration*	*A satisfactory demonstration by student (Initialled by R.N.)*	*Procedure carried out—(No. of times up to four)*	*Observed only (No. of times up to four)*
Chest aspirations				
Pneumothorax				
Pneumoperitoneum				
B. GENERAL WARDS				
1. Admission of a patient				
2. Chemotherapy				
streptomycin				
penicillin				
other				
3. Col. of specimens				
biopsy				
pleural fluids				
sputum				
stools				
urine				
4. Emergency routines				
hemorrhage				
spontaneous pneumothorax				
5. Heliotherapy				
quartz lamp				
6. Patient education				
technique				
treatment routine				
bed rest				
exercise grades				
rest hours				
initial treatments				
disease factors				
7. Records				
8. Referrals				
9. Charting (list)				
10. Techniques				
patient				
visitors				
disinfection methods (list)				
supervision of other personnel (list)				
11. Other experiences (list)				
C. SURGICAL WARD				
1. Chemotherapy (list)				
2. Drainage:				
open				
closed				
suction				
3. Education prior to surgery (list)				
4. Observation of chest surgery (list cases)				
5. Observation in recovery room (list cases)				
6. Thoracoplasty				
weights				
7. Dressings (list)				
8. Records				
9. Referrals				
10. Charting				
11. Other experiences (list)				

NOTE: Each student nurse is responsible for her own records. When these records are returned to you, please place them in your Tuberculosis Notebook.

Rehabilitation in Tuberculosis

JOAN M. R. AINSWORTH

Average reading time — 13 min. 12 sec.

INTRODUCTION

THE DICTIONARY defines the verb "to rehabilitate" as to "re-instate, to restore to former rank, right or privilege." This simple definition is being incorporated in the teaching and thinking of all those who, more than ever today, work with people and with their social and emotional problems. Particularly is the concept of rehabilitation being inculcated into the preparation of all those who are going to work in the health fields.

Each one of us, no matter what our culture, race or creed, is a member of a biological unit —"the family." This unit gives us our sociological introduction to society and is the means by which "the house" of our personality and life is slowly built. Our house will contain several rooms, among them: —education, economic capacity, health — physical, mental, social, and emotional — and manual dexterity. When an individual becomes ill his house is damaged. The damage may be only temporary but in the case of the individual who develops tuberculosis the "dehabilitation" process is of a more permanent nature.

Tuberculosis is a chronic communicable disease, which once it has become active, whether due to primary or re-infection processes, can never be said to be wholly cured. It may become quiescent, non-infective, or arrested, but all too often, unfortunately, results in intermittent recurrences.

So the patient with tuberculosis must be helped to rebuild "his house," not only for his own welfare but so as to prevent damage to "the houses" of those with whom he comes in contact in his daily life as a member of the community. In this rebuilding process he must be prepared for restoration to his former status or, if necessary and possible, a better and more suitable one with its rights and privileges. The mechanics of how this may be accomplished will be considered later; always the problem must be attacked on an individual basis, remembering the limitations imposed by the patient's arrested disease.

BACKGROUND OF REHABILITATION PROGRAMS

It has already been stated that tuberculosis is a *chronic, communicable* disease with a tendency to *recur*. These three factors make it a universal problem for it is no respecter of age, race, or strata of society and appears in all climates and geographic areas.

Since the discovery and isolation of the tubercle bacillus, or as it is preferably known today *Mycobacterium tuberculosis*, by Robert Koch in 1882 much knowledge has been developed concerning the etiology, epidemiology, and treatment of tuberculosis. Still approximately 25 per cent of all patients discharged from a sanatorium in a given year are probably going to become readmissions within a relatively short period of time. With these potential break-downs it will easily be seen that no program for tuberculosis control can be considered complete without the introduction of a rehabilitation program.

A true rehabilitation program should be based on the concept of *ergotherapy* or physical work prescribed as treatment. This process should be as much a part of the patient's treatment as are medical, surgical, and nursing procedures. Like these, too, it should be planned for and instituted as soon as possible after admission. This is usually possible within a month or two, thus allowing time for mental and

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Miss Ainsworth wrote this paper while taking a post-graduate course in tuberculosis nursing at the Toronto Hospital for Tuberculosis. She is now on the staff of King Edward VII Memorial Hospital in Bermuda.

social adjustment to sanatorium personnel and routine. It also allows sufficient time for thorough physical, social, and economic investigation. An interview with the rehabilitation counsellor should be arranged during this period, at which time the patient's educational and social background and personality can be assessed. This interview should provide a basis for planning rehabilitation. Further interviewing and testing can take place once the patient's physical condition has been appraised and graded.

The application of ergotherapy and selection of an industry or employment for the tuberculous must evolve around the following factors:

Those relating to the tuberculous:

1. The work assigned must not include heavy manual labor.
2. There must be no excessive amount of inorganic dust thrown into the air; neither should the atmosphere contain gas fumes or disagreeable odors.
3. The temperature of the working place should not be too high nor should it be too humid.
4. The work should not be seasonal, include rush periods or overtime.

Those relating to the proposed industry:

1. Too much technical skill must not be required. The great majority of tuberculous people are unskilled workers by reason of their poor economic and social status, hence have had insufficient education.
2. There must be diversification of labor and demand should be constant and continual.
3. Capital outlay for introduction and maintenance of the program should not be too high, therefore facilities, centres and means already established should be used whenever possible.
4. Provision should be made for preparation and employment of women as well as men.

Ergotherapy in its true form is preparation for gainful employment, whereas occupational therapy is merely based on diversional instruction. There is now a tendency to combine both therapies according to the individual patient's needs so the factors listed above can be met. As yet such programs are in their infancy in most places. If the vicious circle — formed by infection, treatment, discharge, reinfection — is to be broken such programs will have to be considered by any group interested in the setting up of a scheme for control of tuberculosis.

PROBLEMS TO BE CONSIDERED

We must now consider some of the problems which will be met when planning and setting up a rehabilitation program.

Nothing functions except through people so the first problem to be considered is what type of people are involved and who shall operate the scheme? Under no circumstances should such a program be introduced without adequate previous investigation into facilities and resources available. It should also be assumed that there are sufficient qualified personnel who can be utilized for maintenance, progress and follow-up of the scheme.

For simple classification the people involved are:

1. *Patients* — all age groups, races, social groups.
2. *Operators* — professionally prepared in their own fields — doctors, nurses, social workers, teachers, occupational therapists, librarians, vocational counsellors, etc.

With reference to the patients, their age, prognosis, educational background, emotional stability, manual dexterity, social status, responsibilities, former occupation — was it interesting and satisfying and will it be suitable after discharge — must all be assessed. Whether the patient has any plans for his own rehabilitation, what they are and how he proposes to readjust himself, should be considered.

Very simply, patients may be classified as follows:

1. *Chronics*, male and female, who will not be able to return to full employment at any period.
2. *Housewives*, normally able to return to their homes.
3. *Children*, who will require very specialized handling. They are spending long periods of their formative years in an abnormal atmosphere as compared with most of their fellows. Their education must be continued and interests de-

veloped along lines that will be directed towards goals compatible with their physical limitations.

4. *Incurables*. These people can best be treated with diversional types of therapy.
5. Those patients whose prognosis is such that they can be *completely rehabilitated* into the community. With children this is the most pertinent group to be considered.

The patients must be appraised individually as to work tolerance — whether retraining or specialized training will be necessary.

How is such a scheme going to be operated, administered, and financed? Briefly, through people who are specialists in their own fields. A rehabilitation scheme, if undertaken in a true spirit, surely is a worthwhile example of what can be achieved through group enterprise. The program cannot function if attacked from an individual angle. Just as "the house" we originally spoke of is composed of many rooms, so the external influences of society, which may be described as the building materials for the house, are drawn from many sources — medical, social, educational, spiritual, etc. Each of these is interdependent on the others to form the completed structure. It is from these groups the administrators and organizers are drawn.

Once the mechanics of organization are complete, these people should be aware of their functions:

1. Preparation of the patient for complete rehabilitation into society.
2. Preparation of the public, so that these patients will be received and accepted. Tuberculosis as well as being a communicable disease is essentially a social disease. Social conditions and problems are bound up in its predisposing causes yet, once an individual develops the disease, his social group is often only too willing to ostracize the victims, producing many conflicts and tears, certainly inhibitory to his ultimate rehabilitation.
3. Arrangement for adequate financial and public support of the scheme. Naturally this will depend on the structure and state of the society in which it is to operate. The word education is derived from the Latin *educare* — to lead. So again, educationally minded people in the true sense are essential to the success of the scheme.
4. Provision should be made for aftercare, placement, and follow-up of patients discharged from sanatoria. It will probably take an initial period of at least five years before any assessment can be made on the success of the program. As with any other institution the product turned out will form the basis for appraisal.

THE MECHANICS OF ORGANIZATION

The methods of organization of a rehabilitation program must be planned in accordance with the community which it is to serve. Rural, urban, industrial, and occupational areas will present their individual problems.

In a sanatorium where the rehabilitation process is to commence the committee might be composed of the following people:

1. The admitting nurse, who should preferably be public health trained with experience in the community which the hospital serves and, therefore, fully aware of social conditions in the locality.
2. Head of the sanatorium school, who also should be cognizant of educational, vocational, and technical facilities in the district. If no such school exists teachers from local schools should be utilized.
3. Chiefs of medical staffs — male, female, and pediatric.
4. Head of occupational therapy department. Again if none exists a staff member of a technical school might be employed or, in rural areas, skilled craftsmen.
5. Chief librarian of sanatorium library or again a local librarian.
6. A vocational counsellor or someone experienced in and able to handle people.

Often these roles can be filled by people who are themselves ex-patients and at the same time qualified in a particular field. They should be invaluable in making a success of the program, for not only should they be highly prepared but also they have the patient's point of view, thus providing a basis for mutual understanding.

As with most things this program should begin in a small way and grow with circumstances. All new admissions should be included in the introductory scheme, rather than all patients undergoing treatment. Provision should also be made in the constitution of the scheme for regular meetings of the committee. So the routine of the hospital is not unduly disrupted, male, female, and children's cases should be discussed on separate occasions.

Always the patient should be the centre of the program. It must start from him and end with him. His ability, stamina, character, and qualifications will naturally channel the course. He may be a stream for all his life or develop into a river through wise guidance.

Summary and Conclusions

No mention has been made of the types of rehabilitation schemes at present in force. Roughly they may be classified as:

1. Those which provide for segregation of the tuberculous.
2. Those that do not.

Examples of the former are the Papwater Village Settlement in England and the Altro Sheltered Workshops in New York. It is worthy of note that each of these schemes was conceived and planned to fit into the cultural environment. Village life is a very solid background of English social life and Altro serves an urban commercialized society.

As with any other problem we must start with what we have and find a solution from there. In considering a rehabilitation scheme our problem is a patient who has tuberculosis who must, if possible, be re-instated in the community in which he lives as a self-respecting, self-sufficient amd self-supporting citizen.

Some mention should be made here of the problem that all those who work in Canadian sanatoria at the present time are encountering — the question of rehabilitating many of our new Canadians, among whom, since their arrival here, there seems to have been a high percentage of break-downs. This is probably due to obvious causes. The tuberculosis mortality and morbidity rates in some European countries have jumped nearly 300 per cent during and since World War II. Many of our new Canadians must have been infected and, on coming to Canada where they are not economically or socially adjusted, become an easy prey to re-infection processes.

Here, more than ever before, we are faced with a challenge and reason for inaugurating a rehabilitation program, if these persons are not to be discharged as liabilities who will further swell the ranks of the 25 per cent break-downs already being re-admitted. We have these people, both workers and patients, among us for long periods of time. Are we going to accept the responsibility of preparing them for Canadian citizenship by teaching them English and the foundations of our civic life or are we going to let them remain the victims of circumstances? Many of them come from the oldest cultural heritages in Europe; some were highly qualified in their own fields and here is an opportunity for good placement services. They come from all walks of life as did our own British settlers. We are a young and growing country. We need these people. In many instances, I know from talking with them, they find our lack of tradition and history difficult to understand. We, on the other hand, generally have little idea of their background — social and political. Somehow these concepts must be bridged with education and understanding. We have much to learn from each other and should both grow in the process.

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Diabetes and Tuberculosis

E. I. MacKenzie

Average reading time — 4 min. 24 sec.

In considering diabetes and tuberculosis, it is necessary to keep clearly in mind that diabetes is the primary disease and tuberculosis the complicating one. Tuberculosis is said to occur about four times as frequently in persons with diabetes as in the general population, yet there is a low incidence of diabetes in cases of tuberculosis. What does this indicate? Clearly, that tuberculosis is present in many diabetics but is not recognized. The probable reason for this is that the symptoms of the two diseases are similar. The diabetic condition may be thought responsible for such complaints as loss of weight, anorexia, frequent colds, chills, night sweats, and general malaise. It is believed that tuberculosis comes on in diabetes more insidiously than usual. Therefore by the time it is discovered the advance is great. Also, one must remember that 60 per cent of all diabetes begins after the age of 40 years. It can thus be seen that a great many of the cases of tuberculosis have either died or received treatment before the expectancy age of diabetes is reached. The average age at which the combined diseases are diagnosed, then, is in later life.

When diabetes is not controlled, or is poorly controlled, the advance of tuberculosis is rapid. Even in controlled patients the outlook is serious because the body has two serious diseases to combat, each of which affects the other. The primary disease lowers the body's resistance and the complicating one thrives on this lowered resistance. Tuberculosis increases the severity of the diabetes, making it more difficult to control. The toxins of tuberculosis decrease the carbohydrate tolerance by further depressing the function of the Islands of Langerhans.

Many theories have been suggested to explain why diabetics are predisposed to tuberculosis. One explanation is that when hyperglycemia is present the tubercle bacilli thrive. Dr. Joslin states that an excess of glucose in the blood implies a high percentage of glucose in the tissues. This interferes in some way with normal cell repair and resistance to infection. Another theory is that the increase of glycerol, caused by disordered fat metabolism, provides the tubercle bacillus with one of its best nutrients — glycerin. With poor utilization of fats there is increased acidity of the blood, called ketosis, which is also believed to favor the growth of tubercle bacilli. In uncontrolled diabetes the normal function of the reticule endothelial system is disturbed with decreased resistance to infection.

It is quite obvious that the first consideration is the control of diabetes. Simultaneously the patient must have the best available treatment for tuberculosis. Diet must be carefully controlled with frequent blood and urine examinations. An increase of carbohydrates is usually indicated. The appetite is often poor and must be tempted. If the patient understands the importance of diet in relation to diabetes there will likely be little difficulty in securing his cooperation. With patients who are overweight, a reducing diet is necessary because obesity does not aid the control of tuberculosis and interferes with the improvement of diabetes.

Protamine zinc insulin is preferred because of its slow action. Insulin reactions are said to be no more common in the tuberculous diabetic than in the non-tuberculous. Symptoms such as flushed face, headache, nausea, and dizziness usually occur in the

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Miss MacKenzie, who is a student nurse at the Brandon General Hospital, prepared this material while on affiliation at the Manitoba Sanatorium, Ninette.

early morning when there is no food left to be absorbed and to use up the insulin still being released. For this reason a late evening meal as well as three during the day is advisable. Fluids should be plentiful to prevent dehydration.

Bed rest and care of the skin are very important in the nursing care of these patients. Emotional disturbances may present nursing problems. With patience and understanding the nurse may help in overcoming such problems. If the diabetes is under control, the diabetic with tuberculosis tolerates collapse therapy as well as any other tuberculosis patient.

From the above paragraphs these observations may be made. First, when diabetes is apparently well controlled yet the patient feels poorly, tuberculosis should be suspected. Second, every diabetic should be examined at frequent intervals for tuberculosis. Third, in nursing tuberculous diabetics, the nurse must keep the two diseases in mind at all times. Fourth, when educating tuberculous diabetics equal emphasis must be put on both diseases.

In the Good Old Days

(*The Canadian Nurse*, NOVEMBER 1911)

"Having regard to the large number of operations and the high percentage of cured or improved cases, one cannot but be struck with the thorough yet simple methods of procedure . . . No pad or antiseptic dressing is placed on the field of operation, which is shaved just before going to the operating room. The soap used for the skin and the operator's hands is Jumbo Soap. It is much favored by mechanics for removing grease; it is strongly alkaline, contains pumice, and produces a good lather. It is well suited for the purpose, as it removes loose epithelium and oily substances, leaving the skin smooth as well as clean."

* * *

"The need, in times of severe illness, for continuous skilled nursing in the homes of those of moderate means, for a much lower fee than the graduate nurse must in justice to herself ask, is becoming more apparent every year . . . If all our hospitals having nurses in training could arrange to increase, say by one-third, their present nurse-in-training staff and, in addition to their other courses of instruction, give a course in practical home nursing, the need could be met to a great extent. The fees, not to exceed $1.00 per day, would all be collected by the hospital.

"The advantages to the pupil nurse would be great for she will learn, under instruction, how best to adapt herself to many and various conditions, a thing that will be of great value to her when beginning private practice on her own account."

* * *

"Just one year ago, an announcement was made to the world that a new drug, then called '606', for the treatment of syphilis had been discovered by Erlich."

* * *

"The Victorian Order of Nurses now has a staff of five in Vancouver, for whom a new home is being purchased. The citizens of Vancouver were asked, on September 30, to show their appreciation of the work of the Order by assisting in the purchase of the home."

Three Up—Seven to Go!

That caption sounds a little like the football broadcasts we hear this time of the year on the radio. Perhaps it was inspired by the echoes of a rousing cheer that could have been heard in our offices on October 3 when a telegram was received from Charlottetown that read: "Thirtieth annual meeting Association of Nurses of Prince Edward Island unanimously approved inclusion *Journal* subscription with membership fee. The Island scores again."

Thank you, nurses of Prince Edward Island, for showing your confidence in your *Journal* by joining New Brunswick and Alberta nurses in being 100 per cent subscribers to *The Canadian Nurse*.

Public Health Nursing

Nursing Unlimited?

JEAN LEASK

Average reading time — 6 min. 24 sec.

NURSING UNLIMITED ? — the question mark is important — was the title chosen for a panel discussion of the *Report of the Study Committee on Public Health Practice in Canada* at the annual meeting of the Registered Nurses' Association of Ontario in April, 1951. Although the report is concerned with public health practice and includes, therefore, a study of public health nursing, it was felt that the recommendations regarding the use of nursing time could well be adapted to many nursing fields. The panel was planned jointly by the three Interest Committees—Institutional Nursing, Private Nursing, and Public Health Nursing. In the preliminary meetings the members of the committees found so many common problems, so may suggested topics that it was difficult to choose the few which could be discussed even partially in one afternoon. The four finally selected were:

1. The use of the non-professional worker:
    - (a) the nursing assistant
    - (b) the volunteer
    - (c) the clerical worker
2. Recording.
3. Cooperative relationships.
4. The activity analysis.

District representatives to the three Interest Committees were kept informed of the plans for the discussion and copies of the Report were available for study in advance.

The members of the panel, representing various fields of nursing, were: Miss Helen Carpenter, the university school of nursing; Miss Pearl Stiver, official public health nursing; Miss Helene Snedden, visiting nursing; Mrs. Alma Longeway, industrial nursing; Mrs. Jean Coulter, hospital outpatient department; and Miss Angela Wilson, private nursing. The chairman was Miss Helen McArthur, president of the Canadian Nurses' Association. No formal papers were prepared by the members of the panel and participation was spontaneous both from them and from the discussion group which was composed of 1,000 interested nurses. It would be impossible to record the full discussion here but an attempt will be made to give some of the pertinent points.

THE NON-PROFESSIONAL WORKER

In the discussion of this section of the Report there was no question of the need for the non-professional worker in all fields of nursing. It was unanimously agreed that many more were required and the discussion was mainly concerned with how these workers could be used and their interest maintained. Examples of the use of the certified nursing assistant by hospitals, registries and one branch of the Victorian Order, and the use of the lay worker by the Division of Public Health Nursing of the Toronto Department of Health showed an acceptance of these workers and the need for more. Considerable interest was shown in volunteers and in methods of using them more effectively. There were three main points which contributed to the success of volunteer participation. The volunteers had a leader, they received an

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Miss Leask is assistant district superintendent of the Toronto Branch of the Victorian Order of Nurses.

orientation to the work of the organization, and they were given a feeling of responsibility for the job. The final person in the non-professional group is the clerical worker and here again the discussion centred around the need for the extension of her duties.

One member of the panel expressed very clearly the need for the non-professional worker by suggesting that nurses, rather than trying to develop "more arms and legs" should make the work which is additional to their professional responsibility so challenging that other people would want to come and help them.

RECORDING

The use of clerical personnel in the nursing field led naturally to a discussion of the second point which had been chosen — recording. The need for records, the use which is made of them, and methods of obtaining them are all topics which require careful consideration and analysis. It was evident that much serious thinking is being carried on in all fields of nursing regarding records. Examples were cited from both the hospital and public health fields of studies which have been made of various aspects of recording. It was suggested that groups should continue to analyze the data which they routinely record to determine what is essential and also to evaluate the time spent in recording in relation to the value of the material collected. More thought should be given to the use of clerical workers in recording. They usually require a shorter training, are more available, and perhaps would do the work more accurately. The possibility of unifying hospital and community records and making information more available among hospitals, industry, and the public health field was also suggested as a method of avoiding duplication and thus giving a better service to the community.

In concluding this phase of the discussion it was pointed out that the statistics obtained from records are important in the interpretation to the public of the value of nursing. They illustrate the need for additional funds or for new projects. The purpose of records must always be kept in mind.

COOPERATIVE RELATIONSHIPS

Although there is no definite section of the Report entitled "Cooperative Relationships" the need for study of this topic, as between the various groups of nurses and with other related professional groups, is suggested in several places. Mention was made of the value of shared programs between official public health agencies and visiting nursing organizations, the contribution of the public health nurse on the hospital staff, and the assisttance given by university schools of nursing to the various nursing groups through extension and refresher courses.

One particularly good example was given of improvement in working relationships as a result of this university assistance. Following a series of lectures at a university school of nursing in which 70 industrial nurses without public health training were enrolled, a request was made by these nurses for more information about the work of the nursing division of the local department of public health. A group of industrial nurses met with the district supervisors of the nursing division and, as a result, arrangements were made for them to visit the district offices and talk with the nurses. It was felt this opportunity to meet and discuss common problems was very helpful.

THE ACTIVITY ANALYSIS

The final point chosen by the panel for discussion was the activity analysis. Perhaps this was based on the old adage that "the first shall be last" since the chapter on activity analysis is one of the most important in the Report. Certainly the statement that "an assessment of the work that nurses now perform must be done in each local situation through a job analysis" is fundamental to the implementation of all other recommendations.

Throughout the discussion of the three previous topics the need was brought out for all nurses to determine the activities which are essential, those which could be performed by another professional or non-professional person, and those which could be eliminated. In order to use the non-professional worker effectively, in order to determine what should be recorded and methods of recording, in order to secure better cooperative relationships through establishing the function of each person in the nursing team, an activity analysis is of primary importance.

Suggestions of methods for making an analysis were enthusiastically given by nurses in hospitals, public health agencies, and industry. These ranged from the complete study of all jobs within an organization to the simple but effective idea of the individual nurse analyzing her own job by setting down the responsibilities contained in it and comparing them with a list of the activities she is performing. It was clearly illustrated, too, that no definite set of functions could be given for all nurses doing a certain type of work. Study must rather be carried on at a local level and with due consideration of the local situation. Activities which are necessary in some communities can be eliminated in others.

In her concluding remarks, Miss McArthur pointed out that it was important that the Report of the Study Committee be used not only by the nursing profession as a whole but by the individual doing the job. Each nurse was urged to begin a study of her own activities and not wait for someone else to do it. Individual interest would create group participation. Nursing time is not unlimited !

Celebration in Owen Sound

Many graduates of the School of Nursing, General and Marine Hospital, attended the celebration of the 50th anniversary of the School. The festivities in connection with the anniversary commenced with the graduation exercises on Friday afternoon, June 8, on the hospital lawn, with Miss Edith Dick, director, Nurse Registration Branch, Ontario Department of Health, Toronto, as guest speaker.

That evening, a banquet was held in Knox United Church, the Alumnae Association being hostesses in honor of the graduating class. Graduates from all over Canada and the United States attended. More than 200 people seated themselves by classes, at flower decorated tables. At the head table were the graduating class and distinguished guests — Miss Agnes Macphail, M.L.A. for East York; Hon. Dr. M. Phillips, Minister of Health, and Mrs. Phillips; Mayor and Mrs. E. C. Sargent. The two graduates of the first graduating class in 1903 — Miss Elizabeth Webster and Miss Elizabeth Hall — and two graduates of the 1905 class — Miss Emily Cume of Philadelphia and Miss Mary Sim — as well as former directors of nursing and assistant directors, many occupying important administrative positions in the nursing profession, were present.

Miss Olga Stewart, chairman of the Reunion Committee, with her assistants were complimented for the fine arrangements they had made. In connection with the celebration, a booklet had been prepared by Mrs. J. McKeen, containing pictures and the history of the graduating classes.

Miss Emily Cume was presented with the key to the city of Owen Sound by Mayor E. C. Sargent.

Miss Macphail and Dr. Phillips gave interesting addresses. The program was concluded by the showing of colored movies of the 1949 and 1950 graduation exercises.

On June 9, the nursing staff of the hospital entertained 125 guests, including visitors, the members of the Alumnae, and the graduating class of 1951, at a tea in the nurses' residence. A tour was made of the hospital where new equipment was on display. Many admired the nurses' residence, hospital arrangements, and furnishings.

About 100 graduates and undergraduates attended the Sunday morning service at Knox United Church.

Although the arrangements for the 50th anniversary were a tremendous task, certainly we all felt our efforts were greatly rewarded.

JACQUELINE THOMSON,
Instructor.

Institutional Nursing

Color Therapy in Hospitals

H. ANTHONY CLARK

Average reading time — 10 min. 24 sec.

MUCH HAS BEEN SAID and written on the subject of "Color in Industry." A great deal of research and many experiments have been carried out with manifold objectives; to minimize accident risks, to increase efficiency and production, to improve morale and reduce absenteeism. The incentive to carry out this work in industry is probably due to the profit motive or in nationalized industries to an attempt to make the ends justify the means. Perhaps it is because of the lack of a similar incentive that equally widespread thought and attention does not seem to have been given to the beneficial results which might possibly be achieved by careful design of color schemes in hospitals and sanatoria.

At the end of World War II most hospitals were badly in need of repainting, both inside and out, and the work of redecorating is now proceeding as rapidly as the financial limitations imposed upon the Ministry of Health will permit. Examinations of previous color schemes show a general and deplorable lack of imagination. Dark brown or green dadoes abound, with much too deep a "cream" wall paint above. White, or at the best cream, ceilings and friezes are almost universal. Brown is, of course, the general color for doors, architraves, skirtings and other woodwork.

Often the choice of color schemes in hospitals has been left to the matron or the local house committee, with little or no expert guidance. In many cases such an arrangement is still being continued and seems likely to remain unchanged indefinitely. Surely the successes claimed as the result of good color designs in industry warrant a thorough and more scientific investigation into the possible therapeutic value of the correct use of color in hospitals. The results might well prove to be of inestimable benefit.

Color schemes should always take into account two important factors — the practical and the psychological. To deal first with the practical. Cleanliness being one of the most important considerations in any hospital, it is logical to assume that light colors should be used throughout. The argument in favor of dark colors on dadoes and other surfaces, "because they don't show the dirt and marks," is diametrically opposed to the principles of hygiene. Dirt should be shown up at once and everywhere, when it will receive early attention as a matter of necessity.

It has been found that in corridors and other places where there are dark painted dadoes, the wall surfaces quickly become severely damaged with the careless handling of stretchers and trucks but, where the walls are in light colors, more care is taken and the damage minimized or eliminated. The knowledge that the slightest mark will show appears to introduce a natural, almost subconscious, caution.

Colors can be helpful in affording direction. In large buildings patients and visitors can be guided by distinctive color schemes in passages and staircases leading to different departments. Just as fire appliances are purposely colored bright red to attract

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attention, so can doorways and important points and fittings be colored to be easily recognizable and noticed or, when the contrary is desired, made unobtrusive.

In operating theatres the opinions and prejudices of surgeons vary. The most die-hard stick to all white, others prefer a pale green or blue, while a few vote for all black. White in an operating theatre certainly accords with the principles of a sterilized cleanliness but, to the surgeon engaged on a long and trying session, it can be a distraction and contribute towards mental fatigue.

Those who favor black, or very dark colors, do so because they say that it helps concentration by focussing attention on the relatively small contrasting area of bright light immediately under the operating lamp. There is a danger here, however, that such a startling contrast may overemphasize the surgeon's concentration and also result in rapid mental fatigue. Quiet colors, of not too light a shade, seem to be the best. Steady concentration and absence from distraction can be aided if the patient is covered with, and those attending in the theatre wear gowns of a color to match the general scheme.

In hospital there are two major groups of people to be considered — the patients and the medical and nursing staff. The conditions for each group differ considerably. The patients are all sick in a greater or lesser degree. The staff are well. The hospital staff may work for several years in the same environment. The patients are in the buildings only for temporary periods, varying from an hour or so in the case of out-patients; to days, weeks, and even months in the case of the more seriously ill. Many patients remain within the building and within one ward for many consecutive days and nights, while the staff are continually passing in and out of various rooms and interrupt their spells of duty by leaving the hospital for their homes and normal activities. It should not be forgotten that while the staff are in the vertical position, many patients necessarily remain in a horizontal position.

The psychological reaction of patients to hospital decorative schemes should take a certain degree of priority over that of the staff, although the latter must also be carefully considered. Sick people like cheerfulness. Cheerful colors can go far to produce the right environment. Many people come from drab homes and their spirits need raising as much as possible. In wards, interest and variety can be achieved by painting walls in different but harmonious colors: one long and one short return wall in one color; the other two walls in another. It may be a good idea to use a restful color such as pale green, grey, or fawn on two of the walls, with a more stimulating pink or peach on the others.

If the nursing staff can be induced to take the care and trouble to change the patients occasionally from one side of the ward to the other it would be possible to introduce variety of outlook for those confined to bed for long spells. Even if the patients or beds are not changed over, a change of "color scene" occurs whenever a person turns from one side to the other. Further, a very sick patient could be placed to face the restful color but, as recovery proceeds, a change to face the more stimulating color might help to accelerate convalescence.

Ceilings should always be colored. A white or pale cream ceiling is tiring and uninteresting to look at for any period of time. Many patients may be confined to the recumbent position and forced to gaze at little else but the ceiling for a long time. A restful color is essential for ceilings and it will be an improvement if it is a few shades darker than the walls. Contrary to popular belief a dark ceiling does not lower the apparent height of a room. Rather is the opposite the case. Ceilings of a lighter shade than the walls tend to attract the eyes upwards and thus impose themselves upon the consciousness. Light walls and darker ceilings hold the eyes at normal level and obviate awareness of the latter.

In children's wards it is not uncommon to paint cartoons depicting nursery rhymes and well-known and loved figures around the walls. If similar pictures are applied to the ceiling, many a child can be induced to lie more peacefully in its cot, while its imagination or the nurse weaves stories around the characters seen above.

While on the subject of walls and ceilings it may be noted that a common error in decoration is to color the cornice and frieze of a room to match the ceiling. This is entirely wrong. The cornice is part of the wall and is, in effect, the capital or supporting member. It should, therefore, always be colored in conjunction with the walls (except in elaborate schemes employing colored enrichment), when the result will be far more pleasing as well as esthetically correct. This is especially important where colored ceilings are employed.

Whether the cornice or frieze, where such exist, shall be colored in to match or shall vary from the main wall surface should be carefully considered with regard to the overall proportions of the room. Except in very large, high rooms, the emphasis of dado, wall, and frieze, by the employment of varying colors or shades, introduces a "fussiness" and frequently tends to make the room appear smaller and confuse the general proportions. All furniture and fittings throughout should, of course, be decorated to harmonize with the general scheme, particular attention being given to beds, cots, radiators, bedside lockers, and so on.

Considerable prejudice may have to be overcome if such schemes are to be introduced to any degree. Too many of the medical staff will be found who consider that the choice of colors should be determined by their own particular likes and dislikes, usually of a very conservative nature. In their own quarters their preferences should certainly be indulged as much as possible. Consulting rooms, private offices, nurses' quarters, and so forth are the individuals' own particular sphere. But in the public places and the wards, consideration of the patient should, and must, come first.

It has been found from experience that patients react well to the ideas outlined. Their interest is aroused and they enjoy the colorful atmosphere in which they find themselves. On the other hand the reactions of the staff vary. Many at first quite frankly express dislike but this is probably due to the instinctive recoil of most people when first confronted by something novel and unusual. After a while, as they become accustomed to it, they not only accept but positively like it. This realization dawns when they begin to find that more ordinary color schemes seem dull and uninteresting by comparison. Even if they continue to disapprove of certain colors and combinations of colors employed, against which they may have set prejudices, they find interest in the variety. So both patients and staff may benefit still further by the increased efficiency which results from some relief from the monotony of the routine duty of nurses.

To put these ideas into practice it is necessary that, whenever a hospital is to be decorated, the architect should arrange a meeting with technical representatives from the paint manufacturer and the decorating contractor, to which the principal members of the hospital staff should be invited. A brief exposition by the architect of the objectives, and an explanation as to how these can be reached, is usually all that is necessary to arouse enthusiasm and secure willing and helpful cooperation of all concerned.

Correction

On page 636 of the September, 1951, issue of the *Journal* Miss M. K. McGrath was noted as being in charge of the operating room at the Norfolk General Hospital, Simcoe, Ont. This position has been held since 1948 by Miss Mabel Cheetham.

Aux Infirmières Canadiennes-Françaises

La Directrice du Nursing

SOEUR MANCE DÉCARY, S.G.M., B.SC., M.B.E.

LA DIRECTRICE DU NURSING est la personne responsable auprès de l'administration de l'hôpital, de l'organisation, de la direction et de la surveillance des soins à donner aux malades au point de vue physique, intellectuel, moral, social, et religieux.

Elle doit réaliser un programme éducationnel, en communion avec tout le personnel affecté aux malades; définir les attributions des personnes chargées des départements de malades; en définitive, déterminer un plan de travail qui servira de guide à tout le personnel préposé au service des malades.

La directrice du nursing doit être en rapport étroit avec le directeur général de l'hôpital, afin de fournir les renseignements nécessaires relatifs aux différentes activités du service des malades. Elle doit donner son avis sur tous les problèmes qui viennent en relation avec le nursing. D'autre part, elle doit transmettre à son personnel les directives et renseignements provenant du bureau de direction. Ses principales fonctions se résument ainsi:

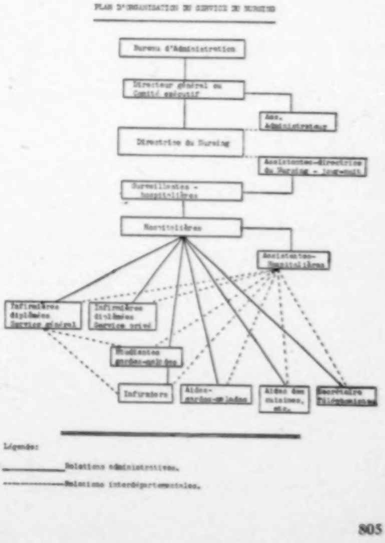
> *Envers l'hôpital:*
>
> Travailler en coopération avec les autorités de l'hôpital. Maintenir un bon service aux malades.
>
> *Envers les malades:*
>
> Voir à ce qu'ils soient bien soignés et à ce que leurs visiteurs soient bien reçus.
>
> *Envers son personnel:*
>
> Offrir une directive sûre pour maintenir un bon standard professionnel et établir de cordiales relations interdépartementales; organiser le travail pour obtenir l'unité de formation, l'unité de méthode, et la continuité dans le travail.

Pour la seconder dans l'organisation, la directrice a besoin de plusieurs personnes ou assistantes, ayant chacune des fonctions bien définies. Ainsi!

La directrice des infirmières s'occupe directement de l'école et des élèves.

Une assistante, conjointement avec la directrice de l'école, s'occupe des infirmières diplômées, aides-malades, infirmiers. Elle s'occupe également du programme éducationnel des infirmières diplômées du service général, des aides et des infirmiers en collaboration avec la directrice du programme d'études de l'école des infirmières.

Une deuxième assistante s'occupe des infirmières du service privé à l'hô-


PLAN D'ORGANISATION DU SERVICE DU NURSING
Bureau d'Administration
Directeur général ou Comité exécutif
Ass. Administrateur
Directrice du Nursing
Assistantes-directrice du Nursing - jour-nuit
Surveillantes - hospitalières
Hospitalières
Assistantes-Hospitalières
Infirmières diplômées Service général
Infirmières diplômées Service privé
Étudiantes gardes-malades
Infirmiers
Aides-gardes-malades
Aides des cuisines, etc.
Secrétaire Téléphonistes
Légende:
Relations administratives.
Relations interdépartementales.

Soeur Mance Décary est directrice du nursing, Hôpital Notre-Dame, Montréal.

pital, du vestiaire, et de l'enregistrement.

La directrice du nursing se réserve directement la formation des infirmières diplômées: surveillantes hospitalières, hospitalières et assistantes hospitalières.

Elle dirige les assemblées d'ordre administratif, éducatif, et scientifique et donne les directives concernant l'organisation des services.

Plan d'Action

1. Enquête préliminaire sur le service actuel des malades, les besoins des malades, les recommandations des médecins chefs de service. Déterminer un plan d'amélioration, s'il y a lieu. Etudier ces suggestions avec les autorités et nos collaboratrices. Après les décisions prises, voir à l'exécution.

Etudier les nouveaux développements de la science médicale et de l'éducation des infirmières pour améliorer nos techniques en conséquence, et ce, constamment.

2. Créer "un esprit de corps" en essayant de promouvoir et de maintenir de bonnes relations sociales entre l'administration, les médecins, les religieuses, les infirmières laïques dans les départements, ainsi qu'avec toutes les personnes venant en relation avec nous: les patients, leurs familles, les amis de l'hôpital, etc.

3. Faire le choix du personnel professionnel et auxiliaire affecté au service des malades. Définir leurs conditions d'emploi, de salaire, de vie, d'alimentation, de service de santé. Etablir un plan de sécurité sociale, de promotion, de condition de travail.

Ce travail se fera en collaboration avec le directeur du personnel. Organiser un programme éducationnel et d'orientation du personnel, pour arriver à l'uniformité. Favoriser les études post-scolaires. Définir les attributions de chacun. Donner à chacun l'autorité nécessaire dans sa sphère d'action.

Etablir des règlements interdépartementaux afin d'arriver à la coordination des services, pour donner un bon rendement en évitant les conflits et les pertes de temps.

Développer le goût du travail, en collaboration, dans l'union et la charité.

4. Travailler à développer la personnalité en donnant à chacun et à chacune la latitude d'émettre leurs opinions personnelles, d'échanger leurs vues, de bénéficier de l'expérience des autres, et leur donner en même temps le privilège de résoudre les problèmes communs.

5. Former des comités pour décider des directives à donner et dans le but d'uniformiser le mode d'organisation, d'administration, et d'éducation dans les départements. Ces comités se composeront:

(a) Des assistantes de jour et de nuit de la directrice du nursing; une séance de 10 minutes chaque matin pour les problèmes journaliers et deux autres fois la semaine pour divers problèmes.
(b) Des surveillantes hospitalières des départements, une fois la semaine.
(c) Des hospitalières des sections de départements, une fois la semaine.
(d) De toutes les catégories énumérées plus haut, avec en plus, les infirmières du service hospitalier, une fois le mois. La directrice du nursing fait partie ex-officio de tous ces comités. Tenir compte de la participation aux discussions et des présences.

6. Former des comités spéciaux pour décider des techniques nouvelles, de médicaments ou de traitements présentant des problèmes d'une portée morale, du règlement des visiteurs, etc.:

(a) Un comité formé des chefs de services et de la directrice du nursing, de ses assistantes, devrait siéger une fois tous les deux mois au moins pour les problèmes d'aspect général.
(b) Pour des départements spéciaux, un comité formé des médecins spécialistes, des infirmières en charge de ces services et de l'institutrice.
(c) Pour ce qui concerne le règlement des visiteurs, un comité formé d'administrateurs, de médecins, et de membres du Nursing.
(d) Pour les problèmes de portée morale: le représentant de l'archevêché, l'hospitalière du département d'obstétrique ou des autres départements, selon les cas.

Le directeur médical et la directrice du nursing font partie ex-officio des comités spéciaux énumérés ci-dessus.

7. Fournir aux surveillantes et aux

hospitalières un plan de distribution des heures de travail, de jours de repos, de vacances, un plan de travail pour leurs aides, etc. Etre à la disposition pour les problèmes journaliers. Diriger le mode d'éducation des élèves dans l'hôpital.

8. Faire donner des cours de surveillance hospitalière, etc.

9. Vérifier les réquisitions journalières et signer celles de la semaine.

10. Etudier l'opportunité d'un nouvel appareil, d'un autre mode de traitement ou d'administration avec les chefs de services.

11. Visiter périodiquement les départements, afin de surveiller le soin des malades et la façon dont chacun s'acquitte de son emploi.

12. Tenir le dossier de chaque personne qui est sous sa juridiction au point de vue conduite, rendement, et façon de s'occuper de son emploi.

13. Transmettre à notre personnel les directives et renseignements fournis par l'administration.

14. Voir à ce que les accidents dus aux médicaments et autres nous soient rapportés immédiatement; exiger les rapports écrits, afin que nous puissions en faire part à qui de droit.

15. Habituer notre personnel à l'économie du temps, de matériel, et d'effort afin d'être en mesure de donner un service adéquat aux malades avec le minimum de dépenses.

16. Rédiger un rapport mensuel et annuel des activités du nursing qui nous permettra d'analyser notre travail, de faire des études comparatives faciles et efficaces. En faire part à l'administration, lorsque requis.

17. Répondre aux appels téléphoniques et à la correspondance relatifs au nursing.

18. Assister et participer aux congrès tenus dans la localité et à l'étranger, afin de se tenir au courant des activités du nursing.

19. Etudier avec l'administration la possibilité d'établir un budget départemental en vue d'assurer un meilleur service aux malades et une bonne organisation dans l'hôpital.

To a Young Nurse

Dear little nurse with your quizzical smile,
Wise head upon shoulders young,
You have chosen a calling well worthwhile,
Do you think you have reached the top rung?

Do you think that all you will have to do
Will be wear a bright medal and don a white dress
And get your diploma, and then you'll be through?
You will not, I'm bound to confess.

Let me tell you, dear child, you'll never be through
As long as you live here below,
As long as there's sickness, and sorrow and pain,
To meet you wherever you go.

You may go to the North, you may go to the South,
You may go to the East or the West
But wherever you go — and I think I should know —
You'll never get much of a rest.

But your life will be full of a number of things,
Glad things, and sad things, and some that are funny.
You will win many joys that do not take wings,
And if you try hard you'll save money!

And when, at the last, at the close of life's day,
You look back o'er years that have flown,
You will not regret one small act of love
Or the hard, trying tasks you have known.

For the "Great Superintendent" of all will come
And place His hand on your brow
And say: "Your work has been nobly done,
You may go off duty now."

— Mary E. Stinson

Miss Stinson graduated from one of the Lakehead hospitals at the turn of the century.

Nursing Profiles

Evelyn Agnes Pepper, R.R.C., has been appointed nursing consultant to the Civil Defence Health Planning Group, Department of National Health and Welfare. Though her headquarters will be in Ottawa, her new duties will carry her all over Canada as she plans and directs the activities of nurses in every province toward the goal of preparedness in the event of war disaster.

Born and educated in Ottawa, Miss Pepper struck out in an unusual direction for a nurse soon after she graduated from the Ottawa Civic Hospital in 1928. She registered in one of the first courses given in radiography and x-ray therapy, held in the Western Division of the Montreal General Hospital. The course was sponsored by the Canadian General Electric Co. Ltd. Subsequently, until her enlistment with the R.C.A.M.C. in 1940, Miss Pepper was senior technician and nurse supervisor of the Department of Radiography and X-ray Therapy at the Ottawa Civic Hospital. She was a fellow of the Ontario Society of Radiographers.

Soon after her enlistment, Miss Pepper was sent overseas with No. 5 Casualty Clearing Station. As Captain (Matron) of No. 3 Canadian General Hospital she saw service in the Italian Campaign during which she was mentioned in dispatches in 1944. As Major (Principal Matron) with No. 1 C.G.H. she was stationed in Holland. She was awarded the Royal Red Cross, first class, in 1945.

Newton, Ottawa

EVELYN A. PEPPER

Miss Pepper enrolled in the course in hospital administration given at the McGill School for Graduate Nurses upon her return from overseas. Her course completed, she joined the Treatment Services of the Department of Veterans Affairs as assistant to the director of Nursing Services. A past president of the Ottawa Civic Hospital Alumnae Association, Miss Pepper is currently president of the Ottawa Unit of the Nursing Sisters' Association of Canada. She is a member of the Professional Institute of the Public Service of Canada and of the Ottawa Women's Canadian Club. But her Irish heart is lightest when she has a fishing rod in her hand.

EVELYN E. HOOD

Evelyn Eunice Hood has assumed her duties as director of Personnel Services of the Registered Nurses' Association of British Columbia. Born in Edmonton, Miss Hood graduated from the University of Alberta Hospital in 1936. After several years working as a general staff nurse in Canada, England, and the United States, she enrolled in the public health nursing course at the University of Washington, Seattle. Two years as supervisor of the venereal disease clinic in Vancouver, Wash., preceded her appointment to the staff of the Metropolitan Health

Committee in Vancouver, B.C., which position Miss Hood relinquished to join the staff of the provincial association.

Miss Hood was elected second vice-president of the Vancouver Chapter of the R.N.A.B.C. She is interested in painting as a hobby and thoroughly enjoys a good game of golf.

John S. Steele

MARJORIE G. RUSSELL

Marjorie Gordon Russell, A.R.R.C., who served as matron-in-chief of the nursing service of the Royal Canadian Navy during World War II, has resigned from her position as director of nurses of the Phillips School of Nursing, Queen Elizabeth Hospital, Montreal, which she had held since 1947. Miss Russell is now nursing consultant for the Department of Veterans Affairs in Ontario. Her headquarters is located at Sunnybrook Hospital, Toronto.

Returning to Toronto was going home for Miss Russell. A graduate of the Hospital for Sick Children in that city, much of her professional life was spent there until she joined the R.C.N. in 1941.

Evelyn Florence Matheson, who last year was awarded the Thomas Wall Scholarship on behalf of the British Commonwealth and Empire Nurses War Memorial Fund and who completed her work for her Master's degree at Teachers College, Columbia University, has accepted appointment as educational director with the school of nursing of the Toronto General Hospital. A graduate from T.G.H. in 1944, Miss Matheson had secured her Bachelor of Arts degree from Acadia University, Wolfville, N.S., before she entered training. She has had experience in private nursing, general staff, and head nurse's duties previously so will have a broad understanding of the various fields of nursing for which the students under her guidance must be prepared.

EVELYN F. MATHESON

De Arquer, N.Y.

HELEN MUSSALLEM

Helen Kathleen Mussallem is now the assistant director of nursing education at her alma mater — the Vancouver General Hospital. Following graduation, Miss Mussallem worked first as a staff nurse in the operating theatre at V.G.H. Then she coupled her diploma work in teaching, supervision and administration in schools of nursing at the University of Washington with post-graduate study in O.R. technique and returned to V.G.H. In 1943 she joined the R.C.A.M.C. and was in charge of the operating facilities in the units to which she was posted both in Canada and overseas.

Upon receiving her discharge in 1946 Miss Mussallem enrolled in the McGill School for Graduate Nurses where she received her Bachelor of Nursing degree. She rounded out her educational background when she completed the work for her Master of Arts degree at Columbia University in 1950. She has been senior instructor at V.G.H. in the intervening years.

That Miss Mussallem believes in carrying her full share of responsibility in the development of her profession is evidenced by the role she plays in provincial association work. She has been chairman of the Institutional Nursing Committee in the Vancouver Chapter, R.N.A.B.C., and is currently honorary treasurer of the R.N.A.B.C. and a member of the provincial Educational Policy Committee. Imbued with a strong sense of the important place nursing occupies in present-day affairs, Miss Mussallem will give active leadership to the students in this large school of nursing.

In Memoriam

Mary Isabella (DeMille) Bacon, who graduated from the Hospital for Sick Children Toronto, in 1925, died in Saint John, N.B., on July 24, 1951, in her 50th year.

* * *

Lola Bell, who graduated from the Winnipeg General Hospital in 1908, died in Victoria on July 22, 1951. Miss Bell was the first school nurse to be appointed in Winnipeg and introduced school nursing in centres in Saskatchewan. She retired in 1943.

During World War I Miss Bell served overseas at Gallipoli, Salonika, Malta and in France. She was awarded the Royal Red Cross in recognition of her devotion to duty.

* * *

Pauline Bissonnette, who graduated from the Ottawa General Hospital in 1928, died on July 29, 1951, after a long illness. She was 46. From the time of her graduation until her final illness, Miss Bissonnette was on the staff of the operating room at O.G.H.

* * *

Avis Geraldine (Hall) Clawson, a former resident of Saint John and Toronto, died in Toronto on July 27, 1951, at the age of 72. Mrs. Clawson graduated in 1901 from the Waltham (Mass.) Hospital Training School for Nurses. She worked in the United States until her marriage in 1910.

* * *

Mary Edna (Dow) Hewitt, who graduated from the Toronto General Hospital in 1911, died suddenly in Saint John, N.B., on July 29, 1951, following a heart attack. Mrs. Hewitt served with distinction with the C.A.M.C. during World War I. On duty in France and in the Mediterranean theatre, she was awarded the Royal Red Cross in recognition of her services. During World War II, Mrs. Hewitt served for a time as commandant of the nursing section of the Red Cross Corps. In 1941, while chairman of the provincial Red Cross outpost hospital committee, she was instrumental in establishing the first outpost hospital in N.B. She had served as matron in the Red Cross Lodge of the Lancaster (D.V.A.) Hospital, Saint John, since it was first opened.

* * *

Isabella MacKenzie, who graduated from the Royal Victoria Hospital, Montreal, in 1928, died in Dauphin, Man., on August 29, 1951, following a brief illness. Miss MacKenzie had engaged in private nursing.

* * *

Margaret McIntyre, an early graduate of the Hospital for Sick Children, Toronto, died on August 9, 1951. Miss McIntyre went to France during World War I to serve with the French Medical Corps. She remained in France to work and during World War II suffered internment.

* * *

Jessie G. Rhodes, who graduated from the Vancouver General Hospital in 1912, died there on July 27, 1951, at the age of 72. Following graduation, Miss Rhodes served for 10 year in the Yukon, mostly at White Horse. Returning to Vancouver, she engaged in private nursing for many years.

* * *

Harriet (Galbraith) Thompson, a graduate of the Royal Columbian Hospital, New Westminster, B.C., died in Seattle, Wash., on July 30, 1951, at the age of 58.

* * *

Ruth A. Wallace, a graduate of the Yarmouth (N.S.) Hospital, died in Halifax on August 10, 1951, after a brief illness. For ten years Miss Wallace was on the staff of the Nova Scotia Sanatorium at Kentville. During World War II she enlisted as a nursing sister with the Royal Canadian Air Force. Subsequently she enrolled for post-graduate work at the McGill School for Graduate Nurses. She was appointed matron of the Halifax Tuberculosis Hospital in 1947.

* * *

Sarah Eleanor Wootton, who graduated from the Montreal General Hospital in 1901, died suddenly in Montreal on August 23, 1951, in her 87th year.

Dr. A. R. Lord Appointed

The Canadian Nurses' Association has announced that an evaluation of the Metropolitan (Demonstration) School of Nursing at Windsor will be undertaken in collaboration with the Canadian Education Association. The latter body has recommended that Dr. A. R. Lord undertake this piece of research. His appointment as director of the Evaluation Program has been made by the Canadian Nurses' Association.

Dr. Lord secured his M.A. from Queen's University, Kingston, Ont. He has served as principal of two of Vancouver's elementary schools, has been inspector of schools in Prince Rupert, Kelowna, and Vancouver. He retired recently from the principalship of the Vancouver Normal School. He is co-author of a World Geography for Canadian schools and was a lecturer on education at the University of British Columbia. He received an honorary LL.D. degree from that university in 1948. Dr. Lord was elected president of the Canadian Education Association in 1947.

It is expected that this study of the program of the Demonstration School will enable the nursing profession to determine whether the implementation of the principles of (a) control of student time and (b) financial independence of the school of nursing would result in the provision of more nurses able to give as good, if not better, nursing care to patients, and to provide a more adequate service to the community.

Refresher Course for Industrial Nurses

A most successful course, held in September at McMaster University, Hamilton, was attended by 120 enthusiastic industrial nurses from all across Ontario, some coming from as far north as Kapuskasing. Of this number 85 were registered for all sessions.

Lectures and discussions centred around public relations, counselling, community resources, emergency care, health education, newer drugs, dermatitis, and records. Nurses were also given up-to-the-minute information on Civil Defence Health Service plans as related to industry.

Tours to local plants were of special interest and well attended. Two Hamilton firms were also hosts to the nurses for a dinner and luncheon.

An evaluation by the nurses themselves indicated that, in the main, the course had met the needs of all the nurses attending.

The excellent support of management in sending their nurses was gratifying to those responsible for planning the course.

On the cover of this *Journal* a group may be seen inspecting an infrared lamp in the medical department of Canadian Westinghouse Co. Ltd. *Left to right* are: ANNE HARDISTY, Barber-Ellis of Canada Ltd., Brantford; MRS. GERTRUDE BYRNE, Galt Metal Industries Ltd.; STELLA LEGRIS, International Harvester Co. of Canada Ltd., Hamilton; LOUISE ALTON, Dominion Foundries and Steel Ltd., Hamilton; ANTOINETTE WILLIAMS, Westinghouse nurse supervisor.

Trends in Nursing

Nursing Shortages

CIVIL DEFENCE plans have focussed attention on the present and prospective shortage of nurses, according to an article in the August number of *Hospital Progress*.

To quote Dr. Howard A. Rusk:

> The current shortage of nurses is the result of increased demand for nursing service. Many factors enter into this picture — the growth in population, the higher percentage of the population living in urban areas; increasing age of the population; increased use of prepayment plans; growth of public health nursing; increased use of nurses in industry.

If there is a shortage of any needed commodity, common sense would seem to indicate that those responsible for the provision of such commodity, in this instance nursing service, must give serious thought to the best methods by which, without sacrificing essentials, a little can be made to go a long way.

In most up-to-date hospitals physical facilities are so planned that the time of the nursing staff is conserved. Miss Marion Wright discusses this problem, under the heading "Making Wise Use of Available Nurse Personnel," in the aforementioned journal. She reminds the reader — first, that nursing service must be patient centred and, secondly, that nursing service must be distinguished from nursing education. Miss Wright briefly states the results of a 60-day study of patient service but notes that this is only one criterion for evaluation. Other factors which play a part in planning staffing patterns are enumerated: (1) amount and kind of supervision and (2) psychological and spiritual factors in patient care.

Do all hospitals make sure—that the patient is visited by the head nurse or her deputy as soon as possible after admission; that the patient knows the name of the nurse responsible for care; that rules and regulations are courteously explained; that an effort is made to have the patient feel a welcome guest? Small courtesies require little, if any, extra time and add to the patient's feeling of security. It could be that this feeling of security might reduce the patient's need to ring the bell and thus cut down on those extra, fatiguing steps.

> No two institutions are the same so it is impossible to set up a tailored plan that will fit them all, but general principles upon which to base planning can be set up. There is one basic principle that I would like to state: we need good nursing administrators who will be the dynamic force in planning and organizing the total nursing service in the hospital.

The Nursing Team

The following excerpt, taken from "Nursing Survey" in the September, 1951, number of *The Modern Hospital*, may be of interest to Canadian nurses:

> The problem at Massachusetts General is being solved by use of a "team plan" of floor nursing. In the team plan, a staff nurse or nurse intern acts as leader for a group. The group may include a licensed attendant, a student attendant, or nursing orderly.
>
> Under the guidance of the nurse, the team cares for a group of patients, each member of the team carrying out the functions for which he or she is prepared. The team leader plans with the head nurse, interprets to the team members the plan for care, and works with them or supervises as the need may be. She cares for the more critically ill or the emotionally disturbed patients in the group, gives medicines, does the treatments which cannot be done by auxiliaries, and teaches the patients whatever is appropriate. This plan relieves the head nurse and enables her to give more oversight to ward activities in general and to patient care in particular. The plan stimulates the staff nurse and makes her work more interesting because she has an opportunity to know her patients better.

> Most important of all, the patients have expressed appreciation for the continuity of care and the interest shown in their individual welfare which the team provides.

"No statistical summary can give a true picture of the seriousness of the shortage of nursing personnel," one administrator observed in replying to the questionnaire distributed by *The Modern Hospital:*

> As I look over our completed questionnaire I am struck with the fact that our situation looks better than it really is. For example, we now have 73 graduate bedside nurses employed and I estimate that we need 80. Consequently it appears that we are short only 7 nurses. However these figures do not show two things which are important. First of all, many of the 73 nurses that we have employed would not be in our employment if I could get some good graduate nurses.
>
> What I am saying is that the quality of personnel is important, as well as the quantity, and the quality does not show up in this questionnaire. For example, I note that we now have 64 nurses' aides in our employment and I estimate that we need only about 50. However, we do not have enough good nurses' aides at present. Most of the 64 we have are of little value and probably should be counted as about one-fifth of one person for purposes of this questionnaire. We are really in bad shape here in our hospital and a break-down in nursing service is a distinct possibility here — yet this questionnaire does not give that picture, since there is no place to indicate the hours that our nursing personnel is willing to work or the quality of people we have employed at the present time.

Other positive approaches suggested in the nursing survey were educational programs aimed at obtaining patient cooperation to eliminate unnecessary demands on nursing personnel, job studies of nursing function to cut down waste motion and make certain as far as possible that professional nurses are not wasting time in non-professional duties, educational programs designed to enlist the aid of physicians in conserving nurses' time.

Nursing Research

October *Trends* carried a brief news item on plans for an activity analysis of the work of the head nurse in a large hospital. It is now the pleasure of the Canadian Nurses' Association to announce that Mrs. Marion Botsford, assistant registrar of the Registered Nurses' Association of British Columbia, has been released for a three months' period to serve as research assistant, together with Mr. C. B. Walker of the Research Division of the Department of National Health and Welfare. Mrs. Botsford, who has had considerable experience in making "time and motion" studies, began her work on September 1 at the Ottawa Civic Hospital where the activity analysis is to be made.

The Biennial Meeting

The 1952 Biennial Meeting will take place in the beautiful and historic city of Quebec. Large numbers of nurses will want to attend because they will want to learn, at first hand, of the progress made in Canadian nursing during the past two years. They will also be interested in participating in plans for the future. Another motive, and one not to be discounted, is the unlimited opportunities offered by Quebec province for a delightful and restful holiday.

The General Meetings will be held in the Chateau Frontenac from June 2 to June 6. National Office will keep you informed through your *Journal* on program developments.

The Secretary's Tour

Miss Gertrude Hall, general secretary of the Canadian Nurses' Association, has within the past year completed a tour of Canada — with the exception of the province of Ontario — by attending meetings of The Association of Nurses of Prince Edward Island, held in the first week of October.

International Council of Nurses

The president and general secre-

tary of the C.N.A. spent part of the month of August in Belgium attending a meeting of the Board of Directors of the International Council of Nurses. Reports concerning this meeting will appear in a later issue.

Orientation et Tendances en Nursing

Pénurie d'Infirmières

Les plans de la défense civile ont démontré clairement que la pénurie d'infirmières, constatée actuellement, s'avérera plus grande dans l'avenir. Tel est du moins l'opinion du Dr. Howard A. Rusk qui s'exprime ainsi dans un article publié dans *Hospital Progress:* "La grande demande des services de l'infirmière a donné pour résultat une pénurie d'infirmières. Bien des facteurs sont en cause — l'accroissement de la population; le pourcentage élevé de la population habitant les centres urbains; la prolongation de la vie à un âge avancé; l'usage de plus en plus répandu des assurances d'hospitalisation; l'augmentation du nursing en hygiène publique; l'emploi plus fréquent d'infirmières en industrie."

Lorsqu'il y a rareté d'un produit essentiel le bon sens indique à ceux qui ont la responsabilité d'assurer le nécessaire à la population — dans l'instance les soins infirmiers — qu'ils doivent penser sérieusement aux moyens à prendre pour que ce produit ne soit employé qu'à bon escient afin d'en prolonger la durée.

Les hôpitaux modernes pour la plupart sont construits de façon à épargner le temps du personnel infirmier. Le problème qui se pose est "l'emploi judicieux du personnel dont l'institution dispose." Ce problème est discuté par Mlle Marion Wright dans la revue déjà citée. Elle rappelle au lecteur, premièrement, que tous les services doivent graviter autour du malade et, secondement, que l'on doit faire la différence entre les soins à donner aux malades et l'enseignement à donner aux étudiantes infirmières. Mlle Wright donne le résultat de 60 jours d'études sur les soins à donner aux malades.

Avant de déterminer le personnel requis pour tel groupe de malades il faut considérer: (1) la quantité et la qualité de la surveillance; (2) si certains facteurs psychologiques et spirituels sont compris dans les soins à donner aux malades.

Est-on certain dans les hôpitaux que: tous les malades sont visités par l'hospitalière ou par son assistante aussitôt que possible après leur admission; le malade connaît le nom de l'infirmière qui prendra soin de lui; le règlement lui est expliqué avec courtoisie. En un mot, qu'un effort est fait pour faire sentir au malade qu'il est le bienvenu.

Ces petites attentions ne prennent pas beaucoup plus de temps et elles contribuent grandement à donner au malade un sens de sécurité. Si le malade se sent en sécurité, il sonnera moins souvent la clochette d'appel; les allées et venues de l'infirmière seront moindres, et la fatigue sera diminuée d'autant.

"Tous les hôpitaux diffèrent un peu des uns des autres. Il est donc impossible d'établir un plan pour déterminer le personnel requis et l'utilisation de ce personnel, mais certains principes généraux peuvent servir de base à tous les plans. Un principe fondamental est le suivant: "Nous avons besoin de bonnes administrations en nursing, d'administratrices qui seront une force et une puissance dans la préparation et l'organisation des soins infirmiers à l'hôpital."

Des Recherches en Nursing

Avec octobre commencera une analyse des activités de l'hospitalière (head nurse) dans un grand hôpital. L'Association des Infirmières du Canada a le plaisir d'annoncer que Mme Marion Botsford, assistante registraire, à l'Association des Infirmières Enregistrées de la Colombie Britannique, a obtenu un congé de trois mois pour faire ce travail à titre d'assistante de M.-C. B. Walker du Département de la Recherche au Ministère National de la Santé et du Bien-Etre. Mme Botsford a acquis une grande expérience dans "l'étude du mouvement." L'Hôpital Ottawa Civic a été l'institution choisie pour y faire cette étude.

L'Equipe en Nursing

Cet extrait d'un article, intitulé "Enquête sur le Nursing" et publié dans *The Modern*

Hospital de septembre, 1951, intéressera les infirmières canadiennes:

"L'équipe en nursing a été la solution d'un problème au Massachusetts General Hospital. L'équipe se compose d'une infirmière qui est chef de groupe, d'une aide certifiée, d'une aide étudiante ou d'un infirmier.

"Sous la direction de l'infirmière, l'équipe prend soin d'un groupe de malades. Chaque membre rempli les fonctions pour lesquelles il a été préparé. Le chef de l'équipe prépare le plan du travail avec l'hospitalière puis elle explique ce plan à l'équipe avec laquelle elle travaille ou surveille selon le besoin. L'infirmière prend soin des grands malades ou de ceux dont les manifestations émotionnelles marquent des troubles du psychisme. Elle administre les médicaments et fait les traitements qui ne peuvent être faits par les aides. Elle est aussi chargée de l'enseignement aux malades.

"Ce plan semble rendre le travail de l'infirmière en service général plus intéressant; elle connaît mieux les malades qui lui sont confiés. Une chose très importante à noter est l'appréciation manifestée par les malades pour l'intérêt continu que chaque membre de l'équipe leur témoigne."

Toujours sur le même sujet, "La Pénurie d'Infirmières," un questionnaire fut envoyé par *The Modern Hospital* aux hôpitaux. Une administratrice fit les remarques suivantes:

"Après avoir répondu à ce questionnaire je suis étonné du fait que notre situation paraît meilleure qu'elle ne l'est en réalité. Par exemple, nous avons 73 infirmières en service général et j'estime qu'il nous en faudrait 80. Conséquemment, l'on pourrait dire qu'il nous en manque sept. Néanmoins ces chiffres ne disent pas toute la vérité. En premier lieu, parmi les 73 infirmières à notre emploi, plusieurs ne le seraient pas si je pouvais les remplacer par de vraies *bonnes* infirmières.

"Je veux dire que la qualité du personnel est aussi importante que la quantité et il n'est pas question de qualité dans ce questionnaire. Un autre exemple — nous avons actuellement 64 aides à notre emploi; leur nombre ne devrait pas excéder 50. Néanmoins, nous manquons de *bonnes* aides, actuellement; les 64 que nous avons n'ont pas une grande valeur et l'on pourrait évaluer leur rendement à un cinquième de celui d'une personne pour le besoin de ce questionnaire. Nous sommes dans une mauvaise position à notre hôpital si l'on considère les différentes catégories de personnel hospitalier. Tout de même ce questionnaire ne donne pas une image réelle de notre situation puisque qu'il y est impossible d'y indiquer les heures de travail durant lesquelles notre personnel infirmier accepte de travailler ou la qualité du personnel présentement à notre emploi."

D'autres suggestions furent faites lors de cette enquête tel que celle: d'instituer un programme d'éducation des malades afin d'obtenir leur coopération et éliminer ainsi toutes sortes d'exigences inutiles à leur rétablissement mais demandant beaucoup de travail au personnel infirmier; de faire l'étude des activités de l'infirmière afin d'éliminer les mouvements inutiles et afin de permettre de juger si l'infirmière n'est pas employée à un autre travail qu'à son travail professionnel et éducationnel; un programme d'éducation des médecins pour atteindre le même but: l'emploi adéquat des infirmières.

L'ASSEMBLÉE BIENNALE

Le congrès biennal de 1952 aura lieu dans la belle ville historique de Québec. Un grand nombre d'infirmières voudront s'y rendre parce qu'elles désirent se renseigner sur les progrès accomplis par les infirmières canadiennes durant ces deux dernières années. Les projets d'avenir les intéresseront également.

Un autre motif propre à inciter les infirmières à se rendre au congrès sont les ressources qu'offre la province de Québec pour des vacances agréables et reposantes. Les assemblées générales se tiendront au Château Frontenac du 2 au 6 juin. Le Secrétariat National vous tiendra au courant dans cette revue du développement du programme.

LES VISITES DE LA SECRÉTAIRE GÉNÉRALE

Mlle G. Hall, secrétaire générale de l'A.I.C., aura visité durant l'année toutes les provinces du Canada, sauf l'Ontario. Elle a terminé ses voyages en assistant à l'assemblée annuelle des Infirmières Enregistrées de l'Ile-du-Prince Edouard en octobre.

CONSEIL INTERNATIONAL DES INFIRMIÈRES

La présidente et la secrétaire générale de l'A.I.C. ont assisté à une assemblée des membres du Comité des Directeurs du C.I.I. tenue à Bruxelles en août dernier.

Rust on bathtubs and sinks may be effectively removed with kerosene.

Nursing at Vellore, South India

FLORENCE TAYLOR, M.SC.

Average reading time — 9 min. 36 sec.

FOR THE PAST six years I have been working in the School of Nursing of the Christian Medical College, Vellore, which is located 86 miles south west of Madras. This is one of the most challenging pieces of work in a field which is full of challenges — namely, nursing education in India. The nursing situation in India is one which causes much concern to all who are engaged in it and also to all who are responsible for the welfare of the people of India. It is difficult to express in any adequate way the immensity of the task. Statistics are cold and uninteresting but a few may help to show something of the present situation. India has a population of some 380 millions. The mortality and morbidity rates are among the highest in the world. To meet this great need India has about 9,000 nurses as compared with 250,000 in the United States, with much less than half the population, or with some 40,000 to care for Canada's 14 to 15 millions.

The problem of more nurses for India is a complex one. Until recent years it was very difficult to get a sufficient number of suitable candidates for the all too few schools. Today it is a little better and we hope the recruitment program will improve year by year. The big problem of the present and future is the building of more hospitals, schools of nursing, and the staffing of these with nurses who have a reasonably high level of training. In view of the acute shortage of nurses and the very few graduate Indian nurses with preparation for teaching, supervisory, and administrative work it will be necessary to have considerable help from nurses from outside India for some years to come.

Money is needed for new buildings, the enlarging of nurses' homes so that the present schools can take in more students, and for study funds for advanced courses for Indian graduate nurses both in India and abroad.

Mission hospitals all over India have contributed largely to the training of nurses. They will continue to do so. Although standards in mission hospitals have been as good or better than in most others they will have to improve in the next few years. New India is setting her house in order. New standards of living accommodation for students of nursing and nurses, of teaching staffs, of teaching facilities and curricula are in the making.

The School of Nursing at Vellore has always been one of the best in India. It has led the way in higher standards, better conditions, and more adequate facilities and staff. The members of the nursing staff have played an important part in national nursing organizations, Christian nursing committees and nurses' examining boards and in every effort to increase the amount and quality of nursing care to patients in India. Perhaps the highest tribute to Vellore nursing efforts is the great demand for Vellore graduates and the large proportion of Vellore graduates chosen for advanced study in India and abroad, by governments and other organizations.

Through the past 30 years or more the basic program has improved year by year under the leadership of Miss Houghton and Miss Vera K. Pitman, two British nurses. One of the first two programs in teaching and supervision for graduate nurses was started in Vellore in 1942. Sixty to 65 nurses have completed the course for the "sister tutor" certificate and of these more than 50 are working in mission hospitals from Quetta in the north to Ceylon in the south and from east to west in India.

In 1945 members of the staff of the Vellore School of Nursing assisted on

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Miss Taylor is on the staff of Vellore Medical College, India.

committees of the Madras University in setting up a four-year basic program in nursing education, leading to the Bachelor of Science (Nursing) degree. In 1946 this program was started at Vellore and at the Madras University convocation in August, 1950, the graduates of the first class received the degree. The emphasis in this course is on public health nursing, a field which heretofore has had to be omitted or practically so. The importance of this development is shown by the words of Major General Bradfield, one-time director of medical and health services of India who, in his report of 1938, stated, "More than anything else India needs public health nurses."[1] The situation has not changed since then. It is hoped that the degree programs in nursing, of which there are two in India, will be instrumental in improving and broadening the certificate course, as well as supplying more nurses with a higher level of training in the basic course for advanced study and eventually for leadership in nursing in India.

> India is a country of contrasts. There is found immense wealth and extreme poverty. There is found great beauty and also much sordidness. The beautiful palaces and gardens of the princes, the fine government buildings and public gardens, the "preserved monuments" such as the "Old Residency" at Lucknow with its lovely garden, and the Taj Mahal with its formal Moghul garden at Agra, are examples of the wonders of man's handiwork in India. Then there are the stately mountains, the Himalayas with their steep peaks and the long ranges of perpetual snows gleaming and glittering in the sun like some frozen masterpiece. In the south are the older mountains with their rounded-off tops, their blue-green forests of eucalyptus trees and lovely tea gardens.
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> The other side of the picture is the villages of the mountains and the plains, the dirt, the unsanitary conditions, the poverty, the famine, the superstition and disease. India's needs are greater than those of any other country, except perhaps China's.[3]

The peoples of India are of many races and origins. They range from the so-called Aryans of the north to the Dravidian groups of the south. Of great interest are the aboriginal tribes, the Todas, Bhils, Nagas and many others, and the Mongolian-like groups near the Tibet and China borders. Customs are many and varied and languages include the Persian-Arabic Urdu language, the many Sanskrit languages such as Gujerati, Hindi and Marathi, as well as many languages of the south which some think to be Dravidian in origin. In all there are 30 or more major languages and over 100 minor ones. This makes transference of workers from one part of India to another very difficult.

Health is a major problem in India. The majority of the people are far below par and many are ill all the time. It is impossible to estimate the morbidity rate but the mortality rates, though not entirely authentic, are some indication of the prevalence of disease. In 1937 it was reported that 200,000 mothers die every year in giving birth to children.

Deficiency diseases and malnutrition account for much of the poor health. "Their diet as a whole is poor as regards nutritive value (both as to calories and vitamins) with the consequence that their general health is below par and deficiency diseases like xerophthalmia, cataract, urolithiasis, emaciation, growth failure, impaired lactation, scurvy, dental caries, pyorrhea, rickets, and even osteomalacia are not uncommon."[2]

The epidemic and endemic diseases such as malaria, plague, cholera, smallpox, relapsing fever, and kala-azar present a big problem. The situation is further complicated by occasional epidemics of influenza and, in late years, of cerebrospinal meningitis and poliomyelitis. Of these diseases Lieut. Colonel J. D. Graham, M.D., wrote, "The list is a formidable one and the different manifestations of most of the epidemic diseases occur on a colossal scale without parallel anywhere in the world save China."

In some parts of India it is estimated that the occurrence of malaria is as high as 50 per cent. The toll of life is very great as is also the very serious impairment of health and loss of many working days for a large proportion of the population. The mortality rate is probably 7 or 8 per 1,000.

Mortality rates for some of the other diseases in various areas of India will give us some idea of the extent of disease. Cholera and plague are much less prevalent than malaria but the mortality rates combined range from a low of .22 to 4 per 1,000. The rate for cholera is lowest in the Punjab where there were 42,651 deaths in one year. The rate for plague was highest in the Punjab where there were 476,938 deaths or 2.32 per 1,000. Smallpox is considered to be fairly well under control but deaths from it in the United Provinces were 60,247 or 0.13 per 1,000.

"Leprosy is engaging the attention of many experts. The British Empire Leprosy Relief Association and the Mission to Lepers are two organizations which are doing invaluable work."[3] Formerly all the leprosy homes and hospitals which received aid from the provincial governments were under the management of the Mission to Lepers. Since independence some of these have been wholly taken over by the government. The incidence of this disease is difficult to discover as the people more often than not try to hide it from the census takers.

Tuberculosis is a great scourge. Actual figures are not available but experts agree that it is very widespread. An estimate of two million cases was considered by many to be much too low a figure. In the past few years World Health Organization B.C.G. vaccine teams have been very busy in India.

With reference to blindness the census enumerators were instructed to include only those totally blind in both eyes. According to their figures the incidence of blindness in 1931 was 601,370 or 172 per 100,000 of the population.

These figures may reveal something of the problem of ill health and sickness in India. The mission hospitals are carrying a real share of the burden. In all such hospitals patients are treated not only with the best modern methods by well-trained doctors and nurses but at the same time with the sympathetic understanding, the love and kindliness and tenderness of the Healer of Galilee. India's sick and troubled millions call to you —"Come over and help us."

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Artificial Respiration

An absolute essential in applying artificial respiration successfully is to be sure that the victim's tongue is pulled out and kept out during efforts to revive him.

A Health League of Canada Committee, under the leadership of the late Sir Frederick Banting, some years ago pointed out that in a large number of apparent drownings there was no water in the lungs but that laryngeal spasm was responsible. If this spasm were relieved in time there was a much better chance of reviving the victim.

Pulling the drowning victim's tongue out, and keeping it out while artificial respiration is being applied, is the only known method up to now of making sure that passage of air into the lungs is not impeded.

Many persons believe artificial respiration to be useless if an unconscious person is taken from the water after more than a few minutes' immersion. As a matter of fact there have been well authenticated stories of the apparently drowned having been resuscitated after an immersion of half an hour.

The only safe rule is to start artificial respiration immediately and to keep it up continuously for not less than four hours or until rigor mortis, a sure sign of death, occurs.

Student Nurses

Thoracotomy

M. COLEMAN

Average reading time — 15 min. 36 sec.

INTRODUCTION

WITH CHEST SURGERY such a young branch of the tree of operative techniques, it is most encouraging to trace the history of a chronic and, in time, wasting condition to its successful termination by surgical intervention. This was my main reason for studying this patient. The chronic nature of his condition, the treatment he received, and his excellent response serve to show how surgery is ever moving forward to battle and win against disease processes in man. I found this case very interesting as I was able to follow this patient's progress from admission to discharge and, perhaps more important, to take part in his nursing care.

From the prevailing symptoms on admission, it was felt that Mr. Svenson had a lung abscess, the etiology of which was not known. The term "lung abscess" in itself is self-explanatory and was given only as a tentative diagnosis. Because of the presence of sputum of a suppurative nature and the chronic character of the condition, an abscess or localized collection of pus, formed by the disintegration of lung tissue, was suspected in the left upper lobe. Following operation, however, a change in diagnosis was made. Microscopic examination of the lung tissue removed indicated a "chronic pneumonitis" or "organizing pneumonia" of a benign nature. Inflammation of the lung tissue of the left upper lobe, probably caused by the pneumococcus bacteria or a virus, produced the exudation into the lung tissue, causing a severe cough with sputum.

Lung tissue is composed of multiple tiny alveoli or air sacs which open into alveolar ducts which, in turn, join together to form into large ducts or bronchioles. The bronchioles meet to form bronchi, which lead into one of the main bronchi and thus into the trachea. Mr. Svenson had a circumscribed suppuration of the left upper lobe. A thoracotomy, with a wedge resection of the involved portion of the lung, was performed.

SOCIAL HISTORY

Mr. Svenson, 44 years of age, was born in Sweden and lived the greater part of his life there. He is a "speeder man" by trade but for four months previous to admission he was unemployed because of his chest condition. He is single, with no family responsibilities, having but one sister living in Sweden. Economically, he had no problems, his hospitalization being cared for by insurance and no family needing support during this period. He was a well adjusted person with no evidence of any mental or racial problem. He had a pleasing personality and was liked by both patients and nurses on the ward.

On admission Mr. Svenson was very apprehensive, speaking frequently of his condition and wondering what the outcome of his operation might be. He was, from the beginning, a most cooperative patient and one who showed a great deal of interest in his surroundings. He was eager to learn about his operation and profited from any health teaching offered to him. He had a fairly good appetite, which

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Miss Coleman is a recent graduate of the Vancouver General Hospital.

improved daily once the importance of his high protein diet was explained to him. He was a well adjusted individual, displaying no problems which would impede our attempts to cure him.

MEDICAL HISTORY

Mr. Svenson was admitted to hospital on August 28 with the tentative diagnosis of "lung abscess, possible carcinoma of the lung." He showed: loss of weight (20 pounds in 4 months); cough; sputum; pain in left chest on breathing.

May 6 saw the onset of the present complaint, when Mr. Svenson stopped working and went to a doctor who sent him for x-rays. No results of these are known. On May 28, the condition was diagnosed as "dry pleurisy" and he was placed on a course of sulfa drugs. The condition seemed to respond favorably for a short period but the symptoms soon returned. He began coughing again, with the production of brown sputum. It was believed an abscess was forming. He was sent to hospital when his breathing became more painful. The abscess broke and he coughed and vomited large amounts of pus. The pain experienced on breathing persisted.

Most of Mr. Svenson's past illnesses have involved the respiratory tract. In 1925 he had "double pneumonia" and thoracotomy for drainage of empyema. While in the army he had tonsillitis and a tonsillectomy was done.

The physical examination revealed no other complications aside from those resulting from his present complaint, which were:

1. Dullness in the left lower lobe.
2. Fine râles in the left lower chest.
3. Bronchial breathing in the mid left chest.

PHYSICAL FINDINGS

A chest plate on admission revealed infiltration of the left upper lobe. There were irregular areas of radio translucency. The remainder of the lung field was clear. On September 1, a bronchoscopy was done. No abnormality was found in the left upper lobe. However, aspirations were sent for cytological examination for cancer. The report revealed the presence of inflammatory cells and fibrin. No malignancy was found though there was a possibility of it.

A chest plate of the left upper lung field the following day paid closer attention to the triangular area of infiltration and the possibility of a bronchogenic neoplasm was stressed. Pneumothorax, introduction of air into the left chest to collapse the lung, was done on the 5th, 7th and 9th of September. Chest plates showed a 20 per cent collapse on the left side with a diminishing area of infiltration, characteristic of a resolving consolidation. A pneumothorax one week later produced no marked change in the degree of collapse. The following week a positive pressure in the left chest made the procedure unnecessary. Following operation, x-ray revealed an almost entirely re-expanded left lung, with no pleural effusion.

All these procedures assisted in establishing a diagnosis and enabled the surgeon to better judge the extent of surgery necessary. These findings in combination with signs and symptoms, and observations by the nursing staff, enabled him to judge the severity of the condition and consequent nature of treatment.

LABORATORY FINDINGS

Urinalysis showed no abnormality.

Blood morphology — on admission, R.B.C.— 3,700,000; hb. — 67%. A degree of anemia was present. W.B.C.— 14,000 indicative of an inflammatory process.

Ferrous sulfate, gr. 5 t.i.d., was continued throughout hospitalization, resulting in a blood count on discharge of: R.B.C.— 4,350,000; hb.— 80%.

Sputum was sent daily during his first two weeks for smears to detect any presence of T.B. All reports were "negative for acid-fast bacilli and a culture produced no growth in six weeks."

Following operation, to prove that malignancy definitely was not present, sputum specimens were sent to The Cancer Institute. Three consecutive specimens were all reported as Class 2 "No Cancer Cells Found." This, in conjunction with microscopic examination of the lung tissue removed, which revealed only a marked increase in fibrous connective tissue, ruled out all possibility of a malignant lung tumor and resulted in the diagnosis of chronic pneumonitis and organizing pneumonia.

NURSING CARE

Preoperative care: From the time of admission to the day of operation, approximately one month, the nursing care was of a general supportive nature designed to: alleviate discomfort from prevailing symptoms; aid in establising a positive diagnosis; prepare him mentally as well as physically for surgery. It is under these three headings that I will attempt to give a summary of this patient's preoperative care.

Mr. Svenson's general condition on admission was fairly good. There was no elevation in temperature, pulse, or respirations nor any outward signs of any acute distress. He complained of a productive cough with unpleasant sputum, some pain in his left chest on breathing, and general malaise. Immediately measures were taken to ensure all possible help in overcoming these discomforts. Complete bed rest during his first few days, though not essential in his case, enabled the nurses to observe the severity of his symptoms more closely and afforded his opportunity to adjust to the ward situation. It also aided in reducing discomfort from breathing. However, staying in bed seemed to cause more concern in the patient so bathroom privileges were ordered. Mr. Svenson seemed happier when allowed to get up and, as he was cautioned not to over-exert or tire himself, he felt no ill effects.

Postural drainage was carried out once daily up to the time of his first pneumothorax. The patient's chest was kept as straight as possible. The time was increased gradually from 5 to 20 minutes daily. Mr. Svenson was encouraged to cough and expectorate. All sputum was observed for color, consistency, and quantity. The treatment was never done immediately before or after meals in order to reduce the possibility of nausea and vomiting. Mouth care was given frequently to reduce the unpleasant odor of his breath and the taste of the sputum. Penicillin and streptomycin were given daily to reduce infection present and also prevent the occurrence of any upper respiratory infection.

The nurse played an active part in the establishement of a final diagnosis. It was our duty to collect and send to the laboratory each day a specimen of sputum. It was our duty to prepare Mr. Svenson for a bronchoscopic examination, which included:

An adequate explanation of the procedure and its purposes; the accurate administration of premedications; and good nursing care following the examination, such as alleviation of throat discomfort with ice chips and gargles and watching closely for choking and dyspnea.

It was also our duty to prepare the patient and equipment for artificial pneumothorax, assist the doctor, and watch for any untoward reactions in the patient such as dyspnea, syncope, or shock. Lastly, but perhaps more important, was our part in the preparation of both his mind and body for surgery. Physical preparation included such measures as the administration of ferrous sulfate to combat the existing anemia, a high protein diet plus Multicebrin tablets to offset body wasting, and the forcing of fluids to ensure against dehydration and encourage the elimination of toxins. Mental preparation came in the form of reassurance, kindness, and patience. This was not difficult for Mr. Svenson was very eager to learn about his condition and simple explanations appeared to ease his mind considerably.

Immediate preoperative care included a sterile preparation of the operative area, an enema, and sedative the evening before surgery. The morning of operation a urine specimen was sent to the laboratory. He received no breakfast and the sterile preparation was checked. One hour preoperatively he received nembutal gr. 3 and one-half hour later morphia gr. 1/6 and scopolamine gr. 1/150.

POST-OPERATIVE CARE

To ensure specialized immediate post-operative care, Mr. Svenson was sent to the post-anesthetic room. His condition was good; pulse 84, B.P. 128/90, color good; he was receiving oxygen by mask, a blood transfusion was running, and sutured into a stab wound in his left chest was a catheter attached to a drainage bottle.

Before describing his nursing care, a short review of post-operative orders is necessary:

1. "Oxygen constantly"— by mask until conscious and then by tent. Because of surgical interference with the respiratory system, maximum ease of breathing and obtaining oxygen must be afforded to keep a high concentration in the bloodstream.
2. "In semi-Fowler's position" when conscious. A chest drain was in place and this position affords maximum drainage.
3. "Morphine gr. ¼" to combat restlessness — given as necessary.
4. "Dilaudid gr. 1/24" to relieve pain — given as necessary.
5. "Penicillin 400,000 units q. 3 h."— an antibiotic to combat infection.
6. "Fluid diet if no nausea"— fluids are important in maintaining healthy tissues and blood volume and in preventing dehydration.
7. "Nembutal gr. 3"— to ensure rest and sound sleep at night.

During his first three days constant observation and care were essential. For this reason Mr. Svenson had special nurses. Discussions with them and the patient enabled me to see what measures were employed to make this period both comfortable and beneficial to his recovery.

Mr. Svenson remained on oxygen for 24 hours and during this period his blood pressure, temperature, pulse, and respirations were checked q. 4 h. Because he was perspiring freely, sponge baths, alcohol rubs, and frequent changing of linen became necessary. When conscious he was placed in semi-Fowler's in an oxygen tent. The drainage tube was connected to a bottle which was kept on the *floor* — and the removal of the exudate was accomplished by his own respirations. The catheter was left in place until drainage ceased on the fifth day. Special precautions were observed by all during the period of drainage:

1. The drainage bottle was left on the floor, never raised above the level of the bed. This was to prevent him, by expiration, sucking back into the cavity secretions already forced out by inspiration.
2. The catheter was clamped when the bottle was emptied or raised off the floor in order to prevent collapse of the lung by introduction of a positive pressure into the space created by expiration.
3. Special care was taken to prevent any restriction of his chest. Garments and bed clothes were kept loose and constant urging and encouragement to move about was given. Mr. Svenson was most co-operative and, painful as it must have been, he changed his position frequently. Deep breathing exercises were commenced and, though morphia was ordered, the patient was kept comfortable without it. Dilaudid gr. 1/24 was given q. 4 h. p.r.n. during the first three days to reduce pain and ensure rest. This drug, having less effect on the respirations of the patient, was used more freely.
4. Special care to mouth was continued post-operatively as vomiting and expectoration of bloody mucus was troublesome. It also helped in preventing an upper respiratory infection.
5. Fluid intake was supplemented by intravenous infusions until intake by mouth was sufficient. Mr. Svenson was troubled with post-operative urine retention and catheterization was necessary. However, as fluids were forced to 3,000 cc., he was able to void naturally on the third day. Bowel elimination was stimulated at this time by cascara and milk of magnesia. No following doses were necessary.

By the sixth day, any discomfort was controlled by Frosst 292 and Mr. Svenson was sitting up in a chair. All sutures were removed on the tenth day, the wound being dry and healing well. Special care was taken to prevent excoriation of the skin around the drain. It was changed frequently to ensure dryness. Because of frequent changing, butterfly straps were used to reduce irritation of the skin. Calamine lotion helped relieve the resulting itchiness after their removal.

From this time to his discharge three days later, progress was rapid and improvement could be seen day by day. Nursing care became less specialized. Reassurance and encouragement played a great part in the success of this period. Possible failure of the cure for the chronic condition haunted Mr. Svenson. By kindness, patience, and understanding these fears were eliminated. Positive proof — the disappearance of his cough and spùtum and gradual regaining of weight resulting in a general feeling of well-being — finally dispelled all his fears.

Mr. Svenson was discharged with instructions to rest for at least a month and to return, if possible, to a type of indoor work where exposure to changing climate and consequent danger of upper respiratory infections might be avoided. The danger of such infections was stressed as they frequently predispose to lung involvement. Oral hygiene, including frequent dental checks, was urged. In addition, instructions were given him not only to avoid overtiring and fatigue but also to eat well and regularly. He was referred to his doctor after discharge and encouraged to return for regular check-ups. No great restriction of activity was necessary and Mr. Svenson, whose prognosis was good, could look forward to returning to a normal healthy life.

The South Shore

GRETA L. SCOTT

The South Shore of Nova Scotia, the sunrise province of Canada, stretches along the counties of Lunenburg, Queens and Shelburne, 125 miles of scenic beauty, each mile different from the last. Here one sees an azure blue bay with white yachts riding serenely at anchor or a land-locked harbor liberally sprinkled with tiny islands. Again, it may be the mighty Atlantic breaking in great white crests at the very edge of the highway. The road turns inland through prosperous farmlands. Sharp curves and steep hills give the traveller new views of nature's grandeur and beauty.

Nova Scotia is an accommodating country and those who seek the lore of the early German settlers will find Lunenburg interesting. Others may trace their ancestors to the early New Englanders who came to Liverpool or the Loyalists to the town of Shelburne. The original settlers of Chester, the first town on our trip down the South Shore, came from Boston in 1759. Twenty miles further on we enter the town of Lunenburg, settled in 1752 by 1,500 German Protestants from Hanover.

Ships are the life of Lunenburg. This is the home of the famous schooner *Bluenose*, undefeated "Queen of the Sea." Here, in September, is held the Fisherman's Exhibition — a gala week indeed! The fishing fleet is in and everyone celebrates. Visit the exhibition and see the species of marine life that exist in the depths of the sea. Of interest, too, is the display of commercial by-products of fish, such as insulin, simulated pearls, and numerous other items. The skin of a certain species of fish is used in the manufacture of a fashionable brand of shoes. It dyes in beautiful colors and is durable.

One has only to turn inland a mile or two to find prosperous farms and gently rolling hills. Historians, too, will be delighted to find in Lunenburg, the second oldest Protestant church in Canada.

Along this South Shore are many salmon rivers. The La Have River, or de la Hève, as it was named by De Monts in 1604, flows through the town of Bridgewater. Not many miles away is the beautiful Medway River. The rivers of Nova Scotia, like nature's gifts, are free. In the spring literally everyone — business man, office worker, laborer, and small boy, along with the wealthy sport from the United States — goes fishing, each as excitedly as the other awaiting a strike from the mighty salmon.

In the fall, when the leaves have turned

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their glorious hues of red, copper, and yellow, the picture repeats itself as everyone goes hunting.

Rich delicacies from the sea, combined with produce of the farm, make the people along the South Shore lovers of good food. What to them is a common everyday dish from December to June has graced a king's table. From these shores lobsters were flown to London to be served at Princess Elizabeth's wedding reception.

Reticence is a characteristic of those living along this shore. These people present to the public the same reserve as greeted the parson of yesteryear when all the family, shining and silent, sat stiff and straight in the parlor and spoke when spoken to. To know their warm hospitality and gay humor one must be a friend welcomed at the kitchen door. Once within this charmed circle, time and the stress of the world drift idly by. The hand of time very lightly touches their faces. Here men and women are truly 80 years young! Their conversation is studded with humorous descriptive words and phrases — oh, so original !

Lest we linger too long in that quiet countryside, let us go on to Liverpool, the home of the privateers' *Rover* and *Liverpool Packet* and many others in the 1800's.

The Rover's lost and gone, my lads,
these hundred years and more,
Among the bones in Davey Jones, or
rotting on the shore —
But when the lights are lit o' nights,
she puts to sea again,
The Carib fisher sees her ghost along
the Spanish Main.

The above lines are from "The Saga of the Rover" by Thomas H. Raddall, author of "The Nymph and the Lamp" and other best sellers, who makes his home in Liverpool.

Liverpool was settled in 1759 by New Englanders of Plymouth stock. It is a town rich in historic interest and legend. On the shores of Liverpool harbor, which never freezes over, is a thriving paper mill exporting newsprint in company-owned ships to United States and New Zealand. A by-product of this mill, sulphite liquor, is piped to an adjacent plant which manufactures compressed and dried yeast, and another product, a pudding powder, the base of which is Irish moss harvested from the sea.

All along the South Shore stretch mile upon mile of fine white sand beaches, all free to those who wish to enjoy them. Even though everyone "goes to the beach" there are great stretches of sand on which only the gulls make a footprint. Nature has been lavishly bountiful in all her gifts to this province by the sea. The climate on the South Shore is temperate. Winter has lost its sting and glamor for snow-covered hills are only a memory while the rest of Nova Scotia may be digging itself out from under a white blanket.

Shelburne is the southern end of the South Shore. Many of the original Empire Loyalists' homes have been destroyed but still today may be seen the wells in the middle of the streets. During World War II a large naval base was established here on a harbor ranking fourth place by the British Admiralty. Here are the MacKay shipyards, famous as builders and designers of ships.

The South Shore has much to offer the nursing profession — three modern hospitals, with an average of 40 beds, one sanatorium in operation, and one hospital in the process of construction. As the hospital is financed and made possible by the people of the community, everyone takes a lively interest in its affairs. Disease and illness being no respecter of small town or city, with accidents for added variety, the work is always spicy and interesting, plus the personal touch of the patient being your next-door neighbor. These hospitals are staffed by graduate nurses and auxiliary workers.

One young graduate, with an adventurous spirit, heads a cottage hospital of 14 beds which serves an area of over 700 square miles of lumbering and woods operations.

Victorian Order nurses and public health nurses are located in each county.

In June, 1952, the annual meeting of the Registered Nurses' Association of Nova Scotia will be held in Liverpool. To all who read these lines we extend a hearty invitation to be with us then and see the South Shore for yourself.

REFERENCES

1. Longstreth, Morris. Down to Nova Scotia.
2. Raddall, Thomas H. The Saga of the Rover.

Individual and group health education activities need to be adjusted to the interests and needs of the people of the community rather than superimposing plans based on what health specialists think the people should know.

A New School of Nursing

An interesting ceremony was witnessed recently by a large gathering of relatives and friends when the first students of the new school of nursing at the Jewish General Hospital, Montreal, received their caps. Included in this first class were: Misses Dorothy Hager, Natalis Kushner, Beatrice Weiss, Shirley Travitsky, Marilyn Regenstreif, Ada Stearns, and Fay Rybach.

No effort has been spared in the construction, decoration, and furnishing of the fine new nurses' residence that houses this new school. It is a completely modern, nine-storey, fire and sound-proof structure. On the main floor are date rooms, a large lounge, and a recreation room. The recreation room is outfitted as a games room where students may entertain guests.

In the building are administrative offices, post office, air-conditioned classrooms, science, diet, and nursing arts laboratories and study rooms. A well equipped and appointed library is on the second floor. Its location was planned so that those who wish to read or study while informally attired may do so safely.

All student bedrooms are single and are equipped with hot and cold running water, medicine cabinet, clothes cupboard and full-length mirror. The furniture is of the built-in type and includes continental bed, dressing table, desk, dresser, and book-shelves. The rooms are attractively decorated in various matched color schemes.

Each floor has 24 rooms, a solarium, lounge room, kitchenette, a personal laundry room, and a bath-and-shower room equipped with facilities for hair shampoo and drying.

There is a sun-deck on the roof which affords a magnificent view of Montreal.

One of the features of the residence is a large and impressive air-conditioned auditorium, equipped for silent and sound motion pictures. The auditorium also serves as a place for dances as well as other forms of entertainment for nurses. It was here the capping was held.

EVELYN KESSLER
Director of Nurses

The Relief of Night Cramps

Night cramps nearly always occur in the muscles of the lower limbs. Patients are usually middle-aged or elderly and the condition may seriously interfere with sleep. While many bedridden patients are victims of painful cramps, they also affect pregnant women and elderly persons who are not confined to bed. Cramps tend to develop during the night and the attacks to return with greater severity and with even less provocation. Those sufferers with some abnormal metabolic defect (e.g., diabetes) or vascular disturbances (varicose veins) are especially prone to this distressing phenomenon. In addition, night cramps may follow any unusual muscular activity, particularly in those individuals who are afflicted with deformities of the feet.

Cramps may greatly inconvenience patients who are being nursed after operations, so that a night nurse may be repeatedly called away from other activities to massage her patient with probably only temporary relief.

Considerable successes with quinine therapy in night cramps have been reported and it can be suggested that nurses, who have to care for patients who are plagued by these painful cramps, should ask the doctor whether he would agree to these patients taking a three-grain tablet of quinine sulphate three times daily. Relief is usually secured on the first or second night but in some cases the cramps may be persistent, so that treatment should be continued for a few days in all cases. If no success is obtained after about 10 days, further administration of the drug is not to be recommended.

For those patients who are not bedridden, but only suffer occasionally from cramps at night-time, it is unnecessary to take the morning dose but one pill at supper and one at bedtime.

These small quantities of quinine are cheap and harmless and may be given with safety to pregnant women. Quinine idiosyncrasy is rare and, if present, should be evident after

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AN ASSISTANT TO THE SUPERINTENDENT OF NURSES

A Registered Nurse is required for the above position. Applicants should possess some Mental Hospital experience and should be capable of teaching in the School of Nursing attached to this hospital.

Salary Schedule: $205.00 — $230.00 per month, less $25.00 for full maintenance (board and room, laundry and uniforms).

The above positions offer regular annual increases, liberal sick leave with pay, 4 weeks' vacation with pay annually and pension privileges.

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the first dose. Quinidine, which is also a cinchona alkaloid, has proved a useful substitute in some cases and, when the doctor who is in charge of the case has given permission, the same dosage of this latter compound may be tried.

—Sir Philip Manson-Bahr, F.R.C.P., in the *Nursing Mirror*, Sept. 7, 1951.

Book Reviews

The Person as a Nurse (Professional Adjustments), by Florence C. Kempf, R.N., A.M. 226 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1950. Price $3.25.

Reviewed by R. Catherine Aikin, formerly Assistant Secretary-Registrar, Association of Nurses of the Province of Quebec.

In "The Person as a Nurse," Miss Kempf clearly demonstrates sympathetic understanding and a genuine interest in assisting student nurses to understand mature behavior in themselves and in others. "It is the premise of the author that only by reasoning activity of the student can meaningful ethics be taught — a personally satisfying code of ethics be developed by the individual." In a realistic and practical way, the student nurse is led to see how she might become aware of her problems, the implications involved in these problems, and how she herself might work out a constructive solution.

The discussions in this book of personal standards, professions, philosophies, the democratic way of life, etc., are excellent. The reviewer's first impression was that some of these discussions were too advanced for the young women who enter our Canadian schools of nursing but, upon further consideration, it was concluded that the material would stimulate the students' curiosity and, as she matures, she will understand more fully the ideas which are presented and will have a more comprehensive goal for which to strive.

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Although not its primary purpose, this book offers some interesting suggestions concerning the structure of a committee on admission of candidates to schools of nursing, guidance programs, a student-faculty co-operative government, a self-evaluation outline — to mention but a few examples.

I found the material well presented and would recommend it as a textbook for a course in Professional Adjustments. However, I think that student nurses would need a great deal of guidance and time for discussion to benefit adequately from its contents.

Maternal Care and Mental Health — A report prepared on behalf of the World Health Organization as a contribution to the United Nations program for the welfare of homeless children, by John Bowlby, M.A., M.D. 179 pages. WHO, Palais des Nations, Geneva, Switzerland, 1951. Price $2.00.

Reviewed by Alma C. Fletcher, Nursing Counsellor, Civil Service Health Division, Dept. of National Health and Welfare, Ottawa.

Dr. Bowlby, in this contribution to the WHO Monograph Series, has made a thoughtful, factual and up-to-date study on the purpose of the family in community and national life.

His report is the result of a study on the needs of homeless children. Although the study was confined to children who were homeless in their native countries, it should be valuable reference material for those working in foster institutions and child placement bureaus.

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Dr. Bowlby has made full use of the data made possible by the disruption and deprivation in European family life during World War II. The statistical tables represent a wide range of parent and child studies. Table VI—"Differences between children who had spent their first three years in a foster institution and controls who had not"— is of special interest.

Chapter 12 — Substitute Families II: Boarding Homes — deals with temporary placements, case work with parents, foster parents and children in placements.

This report actually illustrates the statement "that maternal care in infancy and early childhood is essential for mental health."

Modern Professional Nursing — new and revised edition. General Editor, Mildred Hainsworth, R.R.C., D.N., S.R.N. 4 volumes (1,917 pages). Published by The Caxton Publishing Co. Ltd., P.O. Box 451, Terminal A, 263 Adelaide St. W., Toronto 1. 1950. Illustrated. Price $19.00.

Reviewed by E. Dorothy Arnot, Instructor of Nurses, Wellesley Hospital, Toronto, and associates.

Four of us have collaborated in the task of assessing the usefulness of this set of four volumes in terms of Canadian schools of nursing. We are agreed that they are an excellent source of reference material. Fully indexed, it would be an easy matter to discover any desired information very quickly. We do not hesitate to suggest that both student nurses and graduates would benefit were this set available in the school of nursing library.

The first two volumes cover the subject matter of the preliminary period. The thorough development of the anatomy and physiology material is augmented by the excellent illustrations, many of them in color. There is sufficient first aid instruction to enable the student to handle emergencies she might encounter.

Volume II would familiarize the student with hygiene, bacteriology, and clinical pathology. The theory and practice of nursing, which starts here, continues into Volume III. There are a few incidental procedures which do not correspond with the teaching in our schools. This serves to broaden the student's understanding and tends to do away with the idea that there is only one method of carrying out a procedure. The illustrations of the various types of splints in Chapter 12 are very helpful as a preparation for orthopedic nursing.

Much of the equipment described and illustrated in Volume III is not familiar in our Canadian hospitals. However, there is much useful material in this book. The section on

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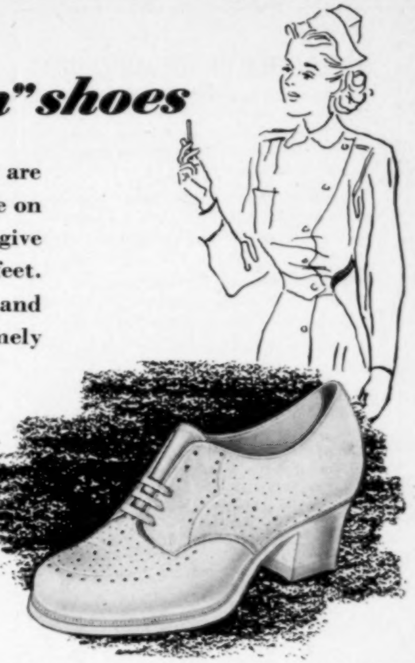

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materia medica is well done, especially the chapters on hormone and vitamin therapy and chemotherapy. There is considerable variance in the dietary instruction given here and in Great Britain. This is especially true of the children's diets—the addition of grated cheese for the six-month-old infant, for example.

Medical nursing chapters set out clearly signs and symptoms of the various diseases. There is a lack of interpretation in terms of actual nursing care of patients showing these symptoms.

The last volume includes surgical, gynecological, obstetric, and pediatric instruction. Some of the highlights are: the differentiation between acute and chronic inflammation; the integration of practical first aid on a surgical ward. The specific treatment of ulcers is interesting for the sake of comparison. Gynecological treatments are very similar to ours. We seem to stress early ambulation more.; This book advocates bed rest for 48-96 hours post-operatively.

The obstetrics is very elementary and so is useful for comparison only. Home delivery is their accepted practice except for abnormal cases. In the section on pediatrics there is good correlation between the normal and abnormal. The author shows great understanding in the handling of children.

The section on the social aspects of disease is most interesting, giving a clear picture of current developments in Britain, including socialized medicine.

There is much solid meat in these books which makes them useful as a reference set, though not a substitute for our divers texts.

Training for Childbirth — A program of Natural Childbirth with Rooming-In, by Herbert Thoms, M.D. 114 pages. McGraw-Hill Co. of Canada Ltd., 253 Spadina Rd., Toronto 4. 1950. Price $3.90.

Reviewed by Eileen E. Jameson, General Hospital, Calgary.

In "Training for Childbirth," Dr. Thoms has given to the medical profession a concise and comprehensive program for natural childbirth, a subject of great interest and significance in the field of obstetrics at the present time. This book, directed primarily to physicians and nurses, gives a detailed

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account of the training program for childbirth carried out as routine for all obstetrical patients in the University Service of the Grace-New Haven Community Hospital.

Dr. Thoms, now professor of obstetrics and gynecology, Yale University School of Medicine, is America's outstanding authority on natural childbirth. The program is outlined in a simple, straightforward manner from the prenatal care of the mother until the end of the postpartum period. Emphasis is placed on childbirth being a natural, normal process. The book includes an educational program designed to prepare both the expectant mother and her husband for the birth of their baby; an outline of the methods of "support' for the pregnant woman, by which labor can be eased and delivery simplified; and finally a discussion on the system of "rooming-in."

First, in the educational program, Dr. Thoms believes that classes should be given to both mothers and husbands, including such topics as the anatomy and physiology of pregnancy and labor, prenatal care, importance of exercise and relaxation to the mother; psychological and physical aspects of labor and pregnancy to the father; infant care to both parents. This program gives them a clear understanding of a normal process and abolishes the pain-fear-tension syndrome of labor.

Secondly, the author recognizes that specialized "support" during labor is the most important single factor in the success of the natural childbirth regimen. The nurses and doctors have the necessary training so that they may have a comprehensive understanding of both the physical and psychological aspects of the birth process. Dr. Thoms gives six attributes of those attending the patient in labor — patience, peacefulness, personal interest, confidence, cheerfulness, and concentrated observation. In our present-day trend towards emphasis on actual nursing care, the importance of these characteristics is evident.

Finally "rooming-in" is presented as a plan which, in its final analysis, lays the foundation for the development of independence and self-discipline. In this hospital arrangement the mother has her newborn baby by her bedside and learns infant care under expert supervision. Dr. Thoms has given a clear picture of a subject which has aroused much popular enthusiasm.

In conclusion, the author gives an honest appraisal of the results achieved by the program and its significance in obstetrics. He believes that the underlying principles of the natural childbirth program are fundamentally sound. Because there is an increasing awareness that the birth process is not somatic but psychosomatic and the emotional reactions of women require consideration as well as the physical condition, this new method will become more and more important to the obstetrician and to the family physician.

Saints, Sinners and Psychiatry, by Camilla M. Anderson, M.D. 206 pages. J. B. Lippincott Co., Medical Arts Bldg. Montreal 25. 1950. Price $3.75.

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Reviewed by Edith M. Pullan, Director of Nursing, Provincial Mental Hospital, Essondale, B.C.

One of the major problems of the modern world is the universal lack of understanding of human behavior. Statesmen, philosophers, clergy, politicians, and sociologists, to name only a few, are ever seeking a solution to this problem.

Dr. Anderson has handled this difficult subject in a very apt manner. There is an absence of psychiatric terminology which allows for easy reading and understandability by the average reader. She has pin-pointed anxiety as the "common denominator" of many of the deviations from normal behavior. Using this as a focus she illustrates how aggression, withdrawal, and physical symptoms develop.

This book would be of particular value to nurses, whether they be students, graduates, head nurses, supervisors, teachers or administrators, if for no other reason than to gain insight into their own personality as well as the personality of colleagues and patients. This book should be in every school of nursing library.

Studies show that children of elementary school age have better average diets than older children. During adolescence boys eat more and get better diets than girls. This poor food selection and consumption by adolescent girls is of real concern in view of the great role played later by proper diet for the pregnant woman and her newborn child.

— *Public Health Nursing*

Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Appointments: *Hazel Wilson* (Ottawa Civic Hosp.; McGill University public health nursing course; University of Toronto advanced course in administration and super-

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For further information write to:

Supt. of Nurses, General Hospital, Winnipeg, Man.

vision) and *Lorna McComb* (Toronto Gen. Hosp. and U. of T. general course) to Kenora-Keewatin area health unit as public health nursing supervisor and staff nurse respectively. The Timiskaming health unit has been formed and includes the former Kirkland-Larder Lake health unit and several additional municipalities. *Mrs. Jean Rhoten* is public health nursing supervisor and the following have been added to the staff: *Muriel Rice* (Lady Minto Hosp., New Liskeard, and University of Western Ont. certificate course), formerly with town of Haileybury; *Isabelle Sorley* (Ottawa Civic Hosp. and U. of T. gen. course) and *Mrs. Helen White* (St. Joseph's Hosp., Winnipeg, and University of Ottawa cert. course) to staff at Kirkland-Larder Lake.

Ethel Hounslow (Brantford Gen. Hosp. and U. of T. gen. course), formerly with Halton County health unit, and *Kathleen Turbitt* (Wellesley Hosp., Toronto, and U. of T. gen. course), formerly with Owen Sound board of health, to Brant County health unit; *Gaetane Laroque* (St. Joseph's Hosp., Sudbury, and U. of Ottawa cert. course) and *Rejeanne Lepage* (U. of Ottawa undergraduate and graduate course) to Prescott and Russell health unit; *Mildred Jarvis* (St. Catharines Gen. Hosp. and U. of T. gen. course), *Phoebe Macnab* (Hosp. for Sick Children and U. of T. gen. course) and *Vera Clark* (Peterborough Civic Hosp. and U.W.O. cert. course) to Northumberland and Durham health unit.

The Stormont, Dundas and Glengarry health unit has appointed the following: *Margaret Atkinson* (Women's College Hosp., Toronto, and U. of T. gen. course and advanced course in admin. and supervision) as senior nurse; *Betty Elliott* (Ottawa Civic Hosp. and U. of T. gen. course) and *Grace Walters* (Kingston Gen. Hosp. and U. of T. gen. course) as staff nurses. The following have been appointed to the newly established generalized service of the Belleville board of health: *Lois Gorman* (Hosp. for Sick Children, Toronto, and U. of T. gen. course); *Mrs. J. C. Watt* (Kingston Gen. Hosp. and U. of T. gen. course), formerly with Belleville board of education.

Jean Falconer (Kitchener-Waterloo Hosp.; U.W.O. cert. course; U. of T. advanced course in admin. and supervision) and *Helen Servage* (Hotel Dieu, Cornwall, and U. of Ottawa cert. course) as senior and staff nurses respectively with Wellington County health unit; *Barbara Sauer* (Chatham Public Gen. Hosp. and U.W.O. cert. course) and *Kathleen Magee*

(Hamilton Gen. Hosp. and U.W.O. cert. course) to Kent County health unit; *Joyce Hickling* (Toronto Gen. Hosp. and U. of T. gen. course) and *Jean Stott* (B.Sc.N., U. of T.) to Halton County health unit; *Barbara Ross* (B.Sc.N., U. of T.) to Etobicoke Township board of health; *Oleavia Chant* (Buffalo City Hosp. and U.W.O. cert. course) to Windsor board of health; *Doris Slocombe* (Toronto Western Hosp. and U. of T. gen. course) to Muskoka district health unit; *Vida Abbott* (Brantford Gen. Hosp. and U. of T. gen. course), formerly with Wellington County health unit, to Waterloo Township board of health; *Caroline Hendrie* (Health visitor from Scotland) and *Muriel Henderson* (Homoeopathic Hosp., Montreal, and McGill U. p.h.n. course) to Welland and district health unit; *Eva* (*Sherritt*) *Rennie* (Regina Gen. Hosp. and U. of T. gen. course) to Leeds and Grenville health unit; *Louise Robertson* (Wellesley Hosp., Toronto, and U.W.O. cert. course) to Bruce County health unit; *Lydia Henry* (Hamilton Gen. Hosp. and U. of T. gen. course) to Elgin-St. Thomas health unit.

Mrs. Eileen Ferguson (Ont. Hosp., Kingston, and U. of T. gen. course) to East York-Leaside health unit; *Mrs. Dorothy Copeman* (Hamilton Gen. Hosp. and U. of T. gen. course) to Hamilton board of health; *Grace Fitzpatrick* (Lorraine School of Nursing, Pembroke, and U. of Ottawa cert. course) to Lambton health unit; *Hilda Willis* (Ottawa Civic Hosp. and U. of T. gen. course) to Lennox and Addington health unit; *Elsie Holden* (Belleville Gen. Hosp. and U. of T. gen. course) and *Sally* (*Stillman*) *Wilkins* (St. Michael's Hosp., Toronto, and U. of T. gen. course) to Oxford health unit; *Norma Lambert* (Regina Gen. Hosp. and U. of T. gen. course) to Prince Edward County health unit; *Heather Matthew* (Sherbrooke Hosp. and U. of T. gen. course) and *Dorothy Sanderson* (T.G.H. and U. of T. gen. course), formerly with Halton County health unit, to Peel County health unit.

Roxina Brandon of Lambton health unit and *Barbara Harvey*, health visitor, Coventry, Eng., have returned to their respective posts after a year's participation in the exchange plan of the Canadian Nurses' Association.

Resignations: *Florence Greenaway* has resigned as regional supervisor with the Ontario Division of Public Health Nursing to pursue post-graduate studies at Wayne University on the completion of which she will return to the nursing education field in Ontario.

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Supervision in Paediatric Nursing.

The following have resigned from Northumberland and Durham health unit; *Mavis Elliott, Elaine (Dogue) Nattress, Anne O'Leary*, and *Jennie Tabacki. Margaret Rattray* and *Elizabeth Russell* from Brant County health unit; *Lorraine (Larsen) Riley, Florence Farr*, and *Esthel Poirier* from Porcupine health unit; *Nora Cumberland* from Etobicoke Township board of health; *Margaret (Wright) Paul* and *Eleanore (Izzo) Piannchietti* from Welland and district health unit; *Phyllis Wingrove* from Wellington County health unit; *Mary McKenna* from Lambton health unit; *May MacCartney* from Leeds and Grenville health unit; *Elsie Hilbert* from Chatham board of health; *Amy Willson* from Lennox and Addington health unit; *Noma Taylor* from Dufferin County health unit; *Marjorie Stewart* from Kirkland-Larder Lake health unit; *Marcelle Latremouille* from Prescott and Russell health unit; *Mrs. D. (Malott) Lemoine* from Kenora-Keewatin area health unit; *Mrs. Jean Wilson* from Strathroy; *Mary Dunsmore* from Waterloo Township; *Ramona Cathcart* and *Edna Crawford* from Windsor board of health.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments—Montreal: *Annette* and *Jacqueline Grégoire* (Hôp. St-Sacrement, Quebec, and University of Montreal). New Liskeard, Ont.: *Agnes Buckingham* (Kitchener & Waterloo Hosp. and University of Toronto) as nurse in charge. Ottawa: *Jeannette* and *Neolla Bellemare* (St. Joseph's Hosp., Three Rivers, and U. of M.). Pembroke, Ont.: *Teresa Hayes* (St. Michael's Hosp., Toronto, and University of Ottawa). Pte. Claire, Que.; *Thérèse Farmer* (Notre Dame Hosp., Montreal, and U. of M.) as nurse in charge. Port Colborne, Ont.: *Dorothy Nicol* (Hamilton Gen. Hosp. and University of Western Ont.) as nurse in charge. Sackville, N.B.: *Vera Hamilton* (Soldiers' Memorial Hosp., Campbellton). Saskatoon: *Fay Harriman* (St. Paul's Hosp., Saskatoon). Toronto: *Susie Beck* (Hosp. for Sick Children, Toronto, and McGill University), *Eileen Carson* (Oshawa Gen. Hosp. and U. of T.), *Betty Foster* (Victoria Hosp., London, and U. of T.), *Anne Jones* (Toronto Gen. Hosp. and U. of T.), *Dorothy Lounsbrough, Marion MacVicar, Ann McKinnon*, and *Mrs. Norma McNamara* (B.Sc.N., Victoria Hosp., London, and U.W.O.), *Georgia*

Poulos (Evangelismos Hosp., Athens, Greece, and U. of T.), *Norma Steeves* (Royal Victoria Hosp., Montreal, and U. of T.), *Katherine Tuttle* (Ottawa Civic Hosp. and U. of T.). Winnipeg: *Genevieve Mustard* (Winnipeg Gen. Hosp.).

Reappointments—Montreal: *Jean Ellis.* Toronto: *Bernice Seeds.* Woodstock, Ont.: *Mrs. C. Etheridge.*

Transfers—*Luba Gold* from Vancouver to Winnipeg; *Vivian Harding* from Galt, Ont., to Calgary; *Beryle Hawley* from Port Colborne as nurse in charge to Montreal; *Frances Jolliffe* from Napanee, Ont., as nurse in charge, to Welland, Ont., as nurse in charge; *Mary McCulloch* from Toronto to York Township, Ont.; *Ellen Pocock* from Toronto to North York, Ont.; *Helen Turnbull* from Toronto to Calgary.

Resignations–Brantford: *Mary Henderson.* Guelph: *Marion Jamieson* as nurse in charge. Halifax: *Gladys MacLennan.* Hamilton: *Mrs. Eileen Tomlinson.* Kingston: *Joyce Brightwell.* Montreal: *Dorothea Atkinson, Mrs. Lorna Davis, Mary Looby, Helen MacAleese, Ruth Neeld, Mrs. V. L. Young.* New Liskeard: *Margaret Sams* as nurse in charge. North Vancouver: *Alice Cannon.* Ottawa: *E. Rhoda Cribb, Betty Wannamaker, June Woodruff.* Pembroke: *Evelyn Redmond.* Saskatoon: *Mrs. Genevieve MacLean.* Welland: *Marguerite Ellsworth* as nurse in charge.

News Notes

ALBERTA

CALGARY

At a recent meeting of Calgary District No. 3 it was decided to send a letter to all active members of the district, giving a calendar of meeting dates until the June meeting and reminding members to watch the "coming events" section of the newspaper each month. Cards are also to be sent, outlining the programs for the coming months. In future, senior student nurses of the General and Holy Cross hospitals will be invited to attend meetings. Miss Connor gave an interesting talk on "The Care and Treatment of Tubercular Patients in Great Britain."

EDMONTON

Royal Alexandra Hospital

A 1941 graduate was selected to accompany Princess Elizabeth and the Duke of Edinburgh on their tour of Canada. She is FO Ella B.

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Director of Nursing,
Mountain Sanatorium,
Hamilton, Ontario.

SUPERINTENDENT OF PUBLIC HEALTH NURSES

The Department of Public Health, Nova Scotia, requires a **Superintendent of Public Health Nurses,** to supervise Staff of three Supervisors and Staff of 50. ***Starting salary,*** $3,624 with annual increases. Civil Service benefits include three weeks' annual leave and Blue Cross. For further details, write, **J. S. Robertson, M.D., Deputy Minister, Dept. of Public Health, Halifax, N.S.**

Application forms may be obtained from
The Nova Scotia
Civil Service Commission,
P.O. Box 943, Halifax, N.S.,
or by telephoning
No. 3-7341-Branch 230.

GRADUATE NURSES WANTED

The Nova Scotia Department of Public Health requires the services of nursing staff for ***Roseway Hospital, Shelburne, N.S.***

1 Operating Room Nurse
1 Night Supervisor
2 General Duty Nurses
2 Nursing Orderlies

Details may be obtained from **Miss Kaye Harvey, Superintendent of Nurses, Roseway Hospital, Shelburne, N.S.**

Application forms may be obtained from the **Nova Scotia Civil Service Commission, Box 943, Halifax, Nova Scotia.** *Phone 3-7341, Branch 230.*

Mannix of Meota, Sask., senior matron of the R.C.A.F. hospital at Rockcliffe, Ont. Miss Mannix was chosen to travel with the royal couple, along with Col. John Crawford, assistant medical director at army headquarters. The two were responsible for medical care and services to the princess and duke and to other passengers on the royal train and plane.

After graduation, Miss Mannix became chief stewardess with Canadian Pacific Airlines and held that position for four years. In 1946 she joined her home hospital, enlisting with the R.C.A.F. in 1948. In March of this year, Miss Mannix was one of two flight nurses serving on the Canadian airlift which carried Canadian casualties home from Korea. She has logged more than 3,000 flying hours with C.P.A. and the air force.

GRASSLAND

Marguerite Ries, district nurse here for the Department of Public Health, forwarded to the *Journal* the accompanying photo of CLEMENT, GRACIE and ROMEO, triplets born to Mr. and Mrs. Holdus. They are shown celebrating their first birthday on July 31 and are the pride and joy of the whole community.

JASPER

At a regular meeting of Edith Cavell Chapter, held at the home of Mrs. Bonner, 12 members and one visitor were present. Correspondence from the Alberta Tuberculosis Association was discussed concerning a visit to Jasper of the Christmas Seal Mobile X-Ray Unit. A committee was formed, consisting of: Mmes Bogan, Brodie, Bruce, Prowse, Recknagle, H. White, and Miss Scott. Mrs. Bruce and Miss Scott will make the initial survey of the town. Vaccinations and inoculations have been carried out at the regular baby clinics. Mmes Anderson, Stewart, Douglas, Recknagle, and Miss Scott have assisted at these clinics.

At the conclusion of business, a film on "Over Dependency" was shown by Mrs. Douglas.

PONOKA

The following officers have been elected by Ponoka District No. 2: President, Mrs. G. Seagrave; vice-president, Miss Stauffer; secretary-treasurer, N. MacDonald; *Canadian Nurse* representative, N. Leckie. At a recent meeting a committee was nominated to investigate the possibilities of setting up a Well Baby Clinic. Civil defence was also discussed.

BRITISH COLUMBIA

NEW WESTMINSTER

Royal Columbian Hospital

Joan Rutherford, a Vancouver General Hospital graduate and a member of the staff here, has left for Hamilton, Ont., to take leadership training for missionary work at McMaster University. Prior to her departure she was entertained by various groups, being the recipient of several gifts.

SUMMERLAND

Verda M. Snow has been appointed superintendent of nurses at the local hospital, replacing M. Bennest who resigned. In addition to considerable experience in eastern Canada, Miss Snow has been employed at the Prince George, Ocean Falls, and Powell River hospitals. Having completed a course in operating room technique, she is well qualified in many departments of hospital administration.

VICTORIA

Royal Jubilee Hospital

Prior to completion of the course in operating room technique and management, an entertainment was held for the first group to finish this special study. In the photo (*left to right*) may be seen: M. UPHAM, JANIE JAMIESON (*supervisor*), F. KING, C. LEASK, and (*in foreground*) E. LAUBACH. Misses Leask and Laubach are R.J.H. graduates — Misses Upham and King, Vancouver General Hospital. By a happy coincidence, the first group completed their course at the time of the Diamond Jubilee of the hospital. Those enrolled in the present class include: M. Chisholm, J. Deslandes, M. Kershaw, M. Moores, S. Reiman.

ONTARIO

DISTRICTS 2 AND 3

STRATFORD

A second assistant registrar has been appointed by the Community Nursing Registry because of pressure of work. She is Eileen (McClean) Smith, a graduate of St. Joseph's

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Victorian Order of Nurses
for Canada,
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(2). ***Obstetrical Nursing***—4 months.

For information apply to:

Director of Nursing
General Hospital
Vancouver 9, B.C.

THE BRITISH COLUMBIA CIVIL SERVICE ***requires—***

PUBLIC HEALTH NURSES, GRADE 1 — (for the Dept. of Health & Welfare, Province of British Columbia).

Salary: $221.50 rising to $248 per mo. Promotional opportunities available for *Public Health Nurses, Grade 2* — $238 rising to $263 per mo. (inclusive of Cost of Living Bonus).

Qualifications: Candidates must be eligible for registration in British Columbia and have completed a University degree or certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province; cars are provided.) Further information may be obtained from the *Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria.*

Candidates must be British subjects, under 40 years of age, except in the case of ex-service women who are given preference. Application Forms obtainable from all *Government Agencies, the Civil Service Commission, Weiler Bldg., Victoria,* or *636 Burrard St., Vancouver 1,* to be completed & returned to the

Chairman, Victoria.

Hospital, Guelph, Mrs. A. Nickles continues as assistant registrar with Mrs. W. J. Byrick as registrar and treasurer. All office administrative duties will be carried on as formerly at the office at 119 St. Vincent St. with the assistant registrars in charge of telephone work only.

DISTRICT 4

ST. CATHARINES

A bronze plaque was unveiled in the Panama Canal Zone in memory of a St. Catharines nurse who organized nursing services in Panama in 1904. Eugenie Hibbard, a member of the class of 1886 of Mack Training School, served as nursing sister in the South African War, then in Cuba where she set up a school for nurses. In 1904 she was appointed head nurse at Ancon Hill Hospital in the Zone during the construction of the canal. After two years spent as nursing superintendent at St. Catharines General Hospital, she organized the Harper Hospital School of Nursing in Detroit in 1889. She died in 1946 in Jamaica at the age of 90.

A picture of the bronze tablet has been presented to the Mack Training School by Jessie Murdock of Jersey City, a former associate of Miss Hibbard.

DISTRICT 9

TIMMINS

At the 27th annual meeting of District 9, R.N.A.O., 53 nurses were present, including delegates from Sault Ste. Marie, Sudbury, North Bay, Timmins, and Kirkland Lake. Ella Roulston, the district's most northern member, attended from Moose Factory. Members were also present from New Liskeard, Matheson, Iroquois Falls, and Cochrane. The chairman, E. Houston, presided. The invocation was given by Dean C. C. Robinson and a cordial welcome was extended by Dr. S. Jessel, chairman of Porcupine Medical Society. Greetings from the city of Timmins were presented by Mrs. J. Larcher in the absence of Mayor Fay.

At the afternoon session, Miss Aiken introduced Dr. G. B. Laine, M.O.H., whose talk on "Tuberculosis," outlining the program of case-finding, diagnosing, treatment, nursing, B.C.G., rehabilitation, etc., proved most interesting. Miss Rotendo thanked the speaker. "Childbirth Without Fear" was the topic chosen by Dr. Marion Powell, who was introduced by Miss Burke. Bringing in the importance of education in the prenatal period, Dr. Powell stated that the patient should be taught that childbirth is a natural procedure with nothing to fear. Dr. Powell was thanked by Miss Lockeberge.

A hundred and sixty-two nurses and guests, including 12 student nurses, attended the banquet when Dr. Charlotte Whitton was guest speaker, introduced by Sr. St. Camillus. Her dynamic and inspiring address was entitled "Nursing and the People's Needs." "All human life is recorded and life is worthwhile but it depends on the individual what she sees and does with it," Dr. Whitton said. I. Black thanked the speaker and, on behalf of the members, presented her with a hand-painted northern scene. The Timmins Chapter was thanked by Miss Thomas for their hospitality.

Sr. St. Camillus, of North Bay, was elected district chairman for the coming months, assisted by J. Thomas and B. Houston as vice-chairmen. Muriel Rice will continue to serve as secretary-treasurer. Other executive members include: Srs. St. Charles Borromie and Sheila, Misses M. Chandler, E. McCready, I. Black, G. Johnson, R. Kennedy, E. Turner.

LITTLE CURRENT

After four years on the staff of St. Joseph's Hospital, Sr. Dympna has been transferred to Blind River to take charge of the hospital there. She has been replaced by Sr. Mary Grace from the Blind River hospital.

QUEBEC

MAGOG

The congregation of St. Paul's United Church recently entertained in honor of Ada Sandell, missionary nurse, who was returning to Korea. She arrived home last November, coming over on a boat with 300 other evacuees. Miss Sandell has travelled all over the Eastern Townships and other parts of Canada, giving talks on her experiences in Korea. She was presented with a beautiful travelling rug, prior to her departure.

MONTREAL

General Hospital

Attention — all Montreal General Hospital graduates! Your representative, Mabel Shannon, would appreciate receiving any news items of interest. Send them to her at the *Nurses' Home, General Hospital, Dorchester St. E., Montreal 18.*

B. Chalmers, I. Riley, and I. Jensen have joined the teaching staff. C. Preston, S. Kinnie, and E. MacKenzie are on the staff at Central Division. B. Jamieson has been at the Royal Cancer Hospital, London, Eng., for the past year. M. Wulffraat and C. Connor are at the Mission Hospital, Bella Bella, B.C. B. Miller is the nurse at Lower Canada College. E. Denman is in the office of Drs. Hodge and Tanton. M. Allen and C. Aikin are doing post-graduate work at the University of Chicago. The following are attending the McGill School for Graduate Nurses: M. Kerr, M. Lewis, C. MacMillan, C. Moore, A. Prescott, and J. Woodruff.

Queen Elizabeth Hospital

A tea was held in honor of Marjorie Russell, who resigned the position of superintendent of nurses at the end of June. (See Nursing Profiles this issue.) She was presented with gifts from the graduate nurses and medical staff. Elsbeth Geiger, a 1942 graduate of the Royal Victoria Hospital, Montreal, succeeds Miss Russell. Miss Greiger has obtained her Bachelor of Nursing degree from McGill University

THE ART AND SCIENCE OF NURSING

By Ella L. Rothweiler and Jean Martin White. New edition of a leading textbook, widely used in schools of nursing. The material has been completely revised. Several new chapters have been added, with more nursing procedures and more illustrations. 895 pages, fourth edition, 1950. $5.00.

ORTHOPAEDIC NURSING

By Frederick J. Knocke and Lazella S. Knocke. A new text that is far ahead of the field. A distinguished group of authorities here give a clear-cut presentation of modern orthopaedics and modern orthopaedic nursing. Fundamentals are stressed. 704 pages, 212 illustrations, 1951. $6.25.

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For particulars apply to Supt. of Nurses at Sanatorium.

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and her M.A. from Teachers College, Columbia University.

Three nurses, who received their certificates from McGill School for Graduate Nurses in teaching and supervision, are back on the nursing staff — L. Henshaw, in charge, 2nd floor; M. Bennett, in charge, 5th floor; M. Saga, assistant head nurse, 4th floor. G. Ewins and J. Edwards, head nurses of the nursery and obstetrical floor respectively, report an enjoyable trip to England and France.

SHERBROOKE

The official opening of the new Sherbrooke Hospital on June 1 brought to realization a dream of many years, providing the city and surrounding townships with a modern institution, ever ready to serve the people irrespective of race or creed. The staff had been working under difficulties in the old building, in use for 65 years, and the space was inadequate to accommodate the waiting list of patients. The new hospital provides every requirement for modern medicine and surgery and the drab coloring is now replaced by soft colors and tints.

J. G. Armitage, president of the hospital, presided at the ceremonies, the Hon. Dr. A. Paquette, provincial Minister of Health, officially opening the hospital. Guests and visitors were taken on tours through the new building and later tea was served in the Norton Residence. The hospital had "open house" to visitors for three days when around 10,000 people toured the building. Two weeks later the patients were transferred.

The first floor is devoted to the administrative offices and technical services. Public wards occupy the second floor, the children's department taking a wing. In charge of this floor is Miss Patton. On the third are private and semi-private rooms and the operating department, with F. Whittle on duty. The maternity department, with Miss Woodman in charge, is on the fourth floor as are miscellaneous types of rooms. In all, the hospital contains 139 beds and 25 bassinets.

Miss Bernard has left for Winnipeg to take a post-graduate course in obstetrics. Miss Alfreda has resigned as O.R. supervisor to be married. At present, she has been replaced by Miss Schofield.

SASKATCHEWAN

SALTCOATS

Anne Prokapition of Yorkton has accepted the position of matron at the Memorial Hospital, filling the vacancy left by the resignation of Doreen MacDonald. Erica Langner of Yorkton has also joined the staff.

SASKATOON

City Hospital

A candlelit capping ceremony took place at the end of August when 30 preliminary students received their caps and were officially accepted into the school of nursing. G. James introduced the students as they entered while the students' candles were lit by Mrs. J. M. Yourk. N. Beggs presented the caps, assisted by I. Hoskin, president, Nursing Students' Association. H. McAdam provided incidental music. The Big Sisters entertained the guests with a musical program followed by lunch. Bouquets were presented by the newly capped students to members of the nursing and instructors offices.

A Big Sister-Little Sister Tea was held in September, sponsored by the 1953-B class.

The members of the 1954-B class were welcomed at this time. Forty-eight students entered the September class. To welcome them to the school, the 1954-A class held a weiner roast. Mr. Schapter of the Charles E. Frosst & Co. spoke to the graduates on "New Drugs."

The following have been appointed to the staff: L. Kangas, nursing arts instructor; E. McAndrews, clinical instructor; Misses A. Anderson, M. Barros, E. Deck, E. Jefferson, L. Kireluik, E. Nicloux, T. Olson, O. Shatula, H. Sproule, Wiebe, M. Zacaruk, N. Zubko. M. Chisholm has left for Victoria to take a post-graduate course in operating room technique, having been awarded a scholarship by the medical staff. Mrs. G. Love, librarian, has left for New Wesminster. On her departure she was presented with gifts from the medical, O.R., hospital and nursing staffs.

St. Paul's Hospital

Forty "Freshmen B" were welcomed to the school of nursing in September when the Reverend Fathers, Sisters, faculty and students met in the auditorium. The following new members of the faculty were introduced: M. Cook, nursing arts instructor; D. Haugen and G. Johnston, clinical instructors; E. Fedoruk, pediatric clinical instructor. E. Lang (3A) social director, Student Association, was mistress of ceremonies, assisted by S. Clark (3B), president of the association. Father C. Kramer, hospital chaplain, awarded a prize for the best display of talent.

September 12 marked the opening of the clinical year at the hospital when the graduate staff participated in the offering of Mass in the chapel at which Father Kramer officiated. Breakfast followed when Sr. Bezaire, superior, introduced the new staff members.

Saskatoon Sanatorium

New staff members include: B. (Angman) Halbauer, M. Henriet, S. Gustavson, O. Kozun, M. Lee, V. Lucke, V. Macknak, H. (Chow) Patterson, J. (Zuck) Saganski, A. Steckler, J. Stubbins, D. (Reid) Wilson, E. Wood. The following nurses have resigned: P. Cutler, D. Delainey, H. Lang, L. Nicholson; J. Johnson and M. Larsen, to go to White Horse, N.W.T.; M. (Torbet) Dunne, R. (Wheatland) Johnson, C. J. (Bishop) Humbert, to make their homes in the U.S.A.; Mrs. F. MacKay to go to Vancouver.

YORKTON

Ardice Ziolkowski, a graduate of the General Hospital, is now serving with the North American Baptist General Missionary Society at Beau in the province of Cameroon, British West Africa. This faraway country will be her home for the next four years, providing, of course, that climatic conditions do not affect her general health. On graduation Miss Ziolkowski merited two awards — the medal for general proficiency and a prize in obstetrics. Prior to taking up nursing, she spent a year at the Bible School in Edmonton.

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Record Librarian for 150-bed hospital. For particulars apply c/o Box J, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal, 25, Que.

Laboratory Technician. Gross salary: $170. 177-bed hospital. For full particulars apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Operating Room Supervisor. Salary: $210 per mo. gross. **General Duty Nurses.** Salary: $165-175 per mo. gross depending on experience. **Night Supervisor.** Salary: $210 per mo. gross. 44-hr. wk. 2½ days holiday per mo. Half day on statutory holidays. 1½ days per mo. sick time cumulative to 30 days. Charge of $30 per mo. made for board & room. Apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Registered or Graduate Nurses (**2**) for modern 20-bed hospital. Salary: $180 & $170 per mo. gross. Usual holiday time & sick leave. Apply E. W. Groshong, Sec.-Mgr., Porcupine-Carragana Union Hospital, Porcupine Plain, Sask.

Graduate Nurses for new 60-bed hospital. Starting salary: $175 & 1 meal. Laundry done. Raises every 6 mos. 7 statutory holidays. No broken time. Apply Supt., Alexandra Hospital. Ingersoll, Ont.

Staff Nurses, eligible for registration in Michigan, for all services in modern 200-bed hospital. Salary: $226 per mo. for 40-hr. wk. 6 mos. increase. $10 extra for 3-11 & 11-7 duty. 7 paid holidays. 2 wks. vacation & 12 days sick leave per yr. Cafeteria meal service. Laundry furnished. Apply Supt. of Nurses, General Hospital, Pontiac 18, Michigan.

Registered Nurses for General Duty. New approved 25-bed hospital. Salary: $250. 5-day-40-hr. wk. 6 holidays per yr. 2 wks. vacation with pay. Liberal policies. Apply Administrator, Del Puerto Hospital, Patterson, California.

Registered Nurses for 60-bed General Hospital. Commencing salary: $150 per mo. plus full maintenance. 44-hr. wk. 3 wks. vacation per yr. & statutory holidays. Apply Supt., Public Hospital, Smiths Falls, Ont.

Registered Nurse for General Duty. 15-bed hospital. Straight 8-hr. shifts at $7.00. Full maintenance, $22.50 per mo. 2 wks. holiday & sick leave with pay. Extra pay for overtime. Apply Sec., Union Hospital, Elrose, Sask.

Graduate Nurses for General Duty (**3**) immediately. Salary: $160 per mo. with full maintenance. 8-hr. day, 6-day wk. 3 wks. holiday with pay after 1 yr. service. Apply, stating qualifications, Sec.-Treas., Little Bow Municipal Hospital No. 25, Carmangay, Alta.

Registered Nurses for General Staff for Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, Smiths Falls, St. Thomas, Toronto, Whitby, Woodstock. Gross salary: $2,260 per annum with maximum salary of $2,660, less perquisites ($26.50 for room, board, laundry). Cumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 44-hr. wk. Apply Supt. of Nurses at above hospitals.

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Operating Room Supervisor for 165-bed General Hospital with expansion program in residential suburb of Chicago. Advanced preparation in operating room technique & at least 2 yrs. experience as head nurse or supervisor preferred. Beginning salary plus complete maintenance in new nurses' residence: $285-315 depending on qualifications. Apply Director of Nursing, MacNeal Memorial Hospital, Berwyn, Illinois.

Operating Room Nurses, General Duty Nurses & Night Supervisors for new 110-bed hospital. Apply Supt. of Nurses, Western Memorial Hospital, Corner Brook, Newfoundland.

Arctic Service — Nurses urgently needed for work in fully equipped Mission Hospital. Apply Diocese of The Arctic, 604 Jarvis St., Toronto 5, Ont.

General Staff Nurses for 60-bed Pediatric-Orthopedic Hospital. For information apply Director, Shriners' Hospitals for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

General Duty Graduates for 105-bed hospital. Beginning gross salary: $170. 8-hr. day, 48-hr. wk. 3 wks. vacation. 10 days sick leave. 7 statutory holidays. Apply Director of Nursing, General Hospital, Galt, Ont.

Graduate Nurses (**2**) for modern 12-bed unit, situated in the mountains 15 miles from Banff. Starting salary: $200. Half yearly increments, $5.00. 1 mo. holiday per yr. or proportion according to length of time worked. 21 days allowable sick leave. Maximum 7-hr. day, 6-day wk. Afternoon & night shift pay differential open. Apply Matron, Canmore Hospital, Canmore, Alta.

Asst. Supervisor for Operating Room of 450-bed General Hospital. Apply, stating qualifications & salary expected, Director of Nursing, General Hospital, Saint John, N.B.

General Duty Nurses (**2**) for 60-bed hospital. 48-hr. wk. Salary: $140 per mo. with 3 annual increments of $5.00. Full maintenance. 4 wks. vacation at end of 1 yr. service. Apply Supt., General Hospital, Goderich, Ont.

General Duty Nurses for Pediatrics; General, Surgical & Medical Nursing for permanent positions. For information & personnel policies write Director of Nursing, Victoria Hospital, London, Ont.

Registered Nurses for General Duty Staff. Salary commences at £37-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

General Duty Nurses for 40-bed hospital. 44-hr. wk. 28 days annual vacation plus 10 statutory holidays. Annual increases & sick leave. Self-contained nurses home. Commencing salary: $185 plus $10 monthly bonus. Full maintenance, $40 per mo. Apply Administrator, General Hospital, Princeton, B.C.

Nursing Arts Instructor & General Duty Nurses for 200-bed hospital. Salaries $195 & $175 plus Cost of Living Bonuses, respectively. 8-hr. day, 88-hr. fortnight. Statutory holidays. Sick time. 4 wks. annual vacation. Apply Supt. of Nurses, Royal Inland Hospital, Kamloops, B.C.

Charge Nurse for Admitting Dept. of Children's Hospital, 250 West 59th Ave., Vancouver 15, B.C., by Jan. 1952. Special qualifications or previous experience in out-patient clinics & admitting office routine necessary. Apply Director of Nursing.

CANADIAN RED CROSS SOCIETY

invites applications for **Administrative** and **Staff** positions in **Hospital, Public Health Nursing Services,** and **Blood Transfusion Service** for various parts of Canada.

- The majority of opportunities are in **Outpost Services** in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia.
- Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

For further particulars apply:

National Director, Nursing Services, Canadian Red Cross Society,
95 Wellesley St., Toronto 5, Ontario.

General Duty Nurses for modern, well-equipped hospital in picturesque Lakehead. 45-hr. wk. Cumulative sick leave. 1 mo. vacation after 1 yr. service. Gross salary per mo.: $185 less $20 for meals. A further $25 charged if living in residence. Annual increment. Railway fare up to $50 with 1 yr. contract. **Pediatric Supervisor** (teaching & administrative). $225. **Asst. Night Supervisor.** Rotating 3-11, 11-7. $225-235 depending on qualifications. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

Vancouver General Hospital requires: **General Staff Nurses**—Salary: $185-215 plus afternoon & night shift differential. Perquisites: 44-hr. wk.; 11 statutory holidays; 28 days vacation; 1½ days per mo. cumulative sick leave; Pension Plan (if under 35). Apply Director of Nursing, General Hospital, Vancouver 9, B.C.

Nursing Arts Instructor for General Hospital, Hamilton, Ont. Nurse experienced in bedside nursing & ward administration & with post-graduate course in Teaching & Supervision required. Initial gross salary bi-weekly: $99 plus Cost of Living Bonus of approx. $3.00. 44-hr. wk. For other perquisites—vacation, illness, pension, etc.—& further information apply Supt. of Nurses.

Graduate Floor Duty Nurses for Mt. Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $79 plus Cost of Living Bonus. For other perquisites & further information write Supt.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $79 plus Cost of Living Bonus of approx. $3.00. 44-hr. wk. For other perquisites & further information write C. E. Brewster, Supt. of Nurses.

General Duty Nurses. Positions available in Alameda, Berkeley, Oakland, Richmond & other California East Bay cities. Nurses registered in their home states or Canada can secure temporary permits to practise nursing in California until Jan. 1, 1954, without examination. Permits may be secured by applying to the Calif. State Board of Nurse Examiners, Sacramento Calif. The following salaries & personnel practices have been established for nurses in the above area: Starting salary: $240 per mo.; $2.50 per mo. tenure increases for each 6 mos. of service to a maximum of 3 yrs. A premium of $10 per mo. paid for night & evening duty; $10 premium also paid for delivery room or operating room duty. 40-hr. wk. 2 wks. vacation for each yr. service. 3 wks. vacation for 5 yrs. service. 7 paid holidays. Sick leave cumulative to 20 work days. Blue Cross Hospital Insurance paid by hospital. For further information write directly to the Director of Nurses of one of the following hospitals: Alameda Hosp., Alameda; Albany Hosp., Albany; Alta Bates Hosp., Berkeley; Children's Hosp. of the East Bay, Oakland; Concord Hosp., Concord; East Oakland Hosp., Oakland; Herrick Memorial Hosp., Berkeley; Martinez Community Hosp., Martinez; Merritt Hosp., Oakland; Peralta Hosp., Oakland; Permanente Hosp., Oakland; Pittsburg Community Hosp., Pittsburg; Providence Hosp., Oakland; Richmond Hosp., Richmond.

Graduate Nurses for completely modern West Coast hospital. Salary: $190 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. **Working Supervisor for Obstetrical Ward.** Salary to commence at $215 per mo. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

O.R. Supervisor with P.G., Scrub Nurse, Night Supervisor & General Duty Nurses for modern 100-bed hospital. Basic salaries respectively: $205, $185, $195, $175 plus present C.O.L. adjustments, $20. 44-hr. wk. 4 wks. annual vacation. Sick time. 10 statutory holidays. Apply Supt. of Nurses, General Hospital, Chilliwack, B.C.

• WANTED •

REGISTERED NURSES & LICENSED PRACTICAL NURSES

for Hospitals & Fully Modern Outpost Nursing Stations.

Beginning Salaries: *Registered Nurses* — $2,160-2,568. *Licensed Practical Nurses* — $1,560-2,040. 44-hr. wk. 3 wks. leave with pay annually.

Apply:

Indian Health Services, Dept. of National Health & Welfare,

522 Dominion Public Bldg., Winnipeg, Man. (Phone—927-100)

General Staff Nurses for Union Hospital, Rosetown, Sask. Salary: $145 per mo. with full maintenance. $5.00 increase after 1 yr. to $20, a maximum in 4 years. 1 mo. holiday with pay per yr. Staff cared for in sickness as necessary. Shifts rotating with 4 wks. days, 2 wks. evenings & 2 wks. nights usually. 6-day wk. Hospital & residence well equipped & maintained. 3 practising doctors. Apply Acting Supt. of Nurses.

Registered Nurse—Floor Supervisor or General Duty Nurse interested in permanent position in pleasant surroundings in small approved sanatorium in southern Michigan city, 70 miles from Detroit. Experience in Tuberculosis Nursing desirable but not required. 40-hr. wk. Vacation & sick leave with pay. 6 paid holidays. Retirement plan. Full or partial maintenance. Minimum salary: $220 & up dependent upon ability & responsibility. Write Miss W. Miller, Supt. of Nurses, Jackson County Sanatorium, Jackson, Michigan.

General Duty Nurses for 107-bed modern hospital. Starting salary: $165 per mo. plus meals & laundry. Additional for night duty. Increases at 6 mos. & annually thereafter for further 2 yrs. 30 days holiday with pay after 1 yr. service. Travelling expenses refunded after 6 mos. from point of entry into Ont. Cumulative sick time. Medical & Hospital plans available. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

Operating Room Supervisor with post-graduate course & experience for 200-bed hospital active service. School of Nursing. Salary: $195-220. For full particulars apply Supt. of Nurses, General Hospital, Moose Jaw, Sask.

Public Health Nurses immediately for Greater Montreal Branch, Victorian Order of Nurses. Interesting program of nursing care & health counselling in homes. Stimulating staff education program. 5-day wk. 4 wks. vacation. Apply District Supt., V.O.N., 1246 Bishop St., Montreal 25, Que.

General Duty Nurses for Queens General Hospital, Liverpool, Nova Scotia. New hospital. Ideal living conditions. 8-hr. day. Blue Cross available. Apply, stating qualifications & experience, to Supt.

Graduate Nurses for General Duty (2) immediately. Salary: $175 with annual increment of $5.00. Board, $26. 44-hr. wk. 28 days holiday after 1 yr. service. Sick leave, 1½ days per mo. Fare advanced if required. Apply Matron, Slocan Community Hospital, New Denver, B.C.

Registered or Graduate Nurses for 40-bed hospital, 40 miles from Ottawa with good bus & train accommodations. 8-hr. day. 3 wks. holiday & 2 wks. sick leave annually. Also 7 statutory holidays. Apply Supt., Arnprior & District Memorial Hospital, Arnprior, Ont.

Registered Nurses for General Duty in 200-bed hospital. Salary: Days, $140; evenings, $150; nights, $145—plus maintenance. 21 days vacation. Increments & cumulative sick leave. **Certified Nursing Assistants.** Salary: $100 plus maintenance. 21 days vacation. For further information apply Director of Nursing, County General Hospital, Welland, Ont.

Graduate Nurses for Operating Room, General Duty & Neurosurgery. Apply Director of Nursing, Victoria Hospital, London, Ont.

Graduate Nurses (2) for 56-bed hospital in North-Central B.C. Basic salary for B.C. registrants: $185 gross; $44.25 deductions for full maintenance in newly constructed residence. Ample recreational facilities. Apply, giving particulars of training & experience, Miss M. Rowe, Supt. of Nurses, Wrinch Memorial Hospital, Hazelton, B.C.

• A Guide for Teachers of Prenatal Classes . . .

prepared and published by a committee comprised of Public Health Nurses and Nutritionists on the staffs of the Public Health Depts., the Visiting Nurses' Associations and the Visiting Homemakers' Association in Toronto, is now available. The subject matter has been reviewed and approved by the Depts. of Obstetrics, Pediatrics & Psychology of the University of Toronto. The Guide suggests how to organize classes in the community where they do not exist; outlines in simple and practical form the subject matter for a series of 10 classes; and includes a list of references, sample forms, as well as other valuable material. These Guides will be of assistance to Public Health Nurses conducting classes and to those interested in organizing classes in their community. ***Cost, $1.00.*** *Apply to:* **Sec., Health Division, Welfare Council of Toronto, 100 Adelaide St. W., Toronto 1, Ont.** (*Make cheques payable to Welfare Council of Toronto.*)

British Columbia Civil Service requires: ***Registered Nurses for General Staff Duty for the Division of Tuberculosis Control***—*Vancouver Unit:* 225-bed T.B. Hospital, located at 2647 Willow St., Vancouver. All major services & student affiliation course. Registration in B.C. required. Gross salary: $182 per mo. Annual increments of $60 (over 5-yr. period). No residence accommodation. *Tranquille Unit:* 350-bed T.B. Hospital, located 12 miles from Kamloops in southern interior. All major services except student affiliation. Gross salary: $188.50 per mo. Annual increments of $60 (over 5-yr. period). New modern residence; attractive bed-sitting rooms. Recreational facilities. Main tenance deduction: Room $5.00; laundry $2.50. Excellent food at 20 cts. per meal. ***Conditions—Both Units*:** 8-hr. day, 5½-day wk. rotating shifts. 4 wks. annual vacation with pay plus 11 statutory holidays. Sick leave, 20 days per yr. (14 cumulative). Promotional opportunities. Superannuation. Write for information & applications to Supt. of Nurses in respective Units or to Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver 9, B.C.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $125 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end each mo. 1 mo. annual vacation. 14 days sick leave. Apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $175-213 plus $20 C.O.L. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Instructor of Nursing & Clinical Supervisor. Apply Director of Nursing, Victoria Public Hospital, Fredericton, N.B.

General Staff Nurses for 270-bed Tuberculosis Hospital—Medical, Surgical & Pediatric Services. Salary: $125-150 per mo. plus full maintenance. New modern residence. Attractive working hrs. 1 week-end ea. mo. Cumulative sick leave. Pension plan. For further information apply Director of Nursing, Tuberculosis Hospital, East Saint John, N.B.

General Duty Nurses for 680-bed General Hospital with School of Nursing. Beginning salary: $255 with $10 additional for special services, p.m. & night shifts. $13 increase after 6 mos. $14 additional increase 1 yr. after 1st increase. 40-hr. wk. 11 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Full maintenance if desired at $45 per mo. Apply Director of Nursing Service, General Hospital, Fresno, California.

Public Health Nurse (qualified). Salary according to experience. Car provided or car allowance. Desirable position close to Toronto. Apply Medical Officer of Health, York County Health Unit, Newmarket, Ont.

Industrial Nurse for large manufacturing plant near Medicine Hat. Must be qualified. Salary: $220 per mo. Pension & insurance plans available. Regular hours. Apply Dominion Glass Co. Ltd., Redcliff, Alta.

Matron & General Duty Nurse (2 nurses with Missionary interest) for 25-bed United Church Hospital on B.C. Coast. Urgent. Excellent opportunity for nurses wishing to serve their church. Majority of work with native Indians. Write for particulars Medical Supt., General Hospital, Bella Coola, B.C.

Matron for 18-bed hospital. Salary: $250 less maintenance. **General Duty Nurses** for southern interior B.C. hospital. Salary: $200 less maintenance plus $5.00 night duty. Annual increment. 44-hr. wk. 3 rotating shifts. 4 wks. holiday with full salary. Fare up to $50 refunded after 1 yr. service. **Operating Room Nurse.** Salary: $210. Balance of terms of employment as above. Apply Creston Valley Hospital Association, Box 30, Creston, B.C.

Registered Nurses (**6**) immediately. Salary: $185 per mo. less $45 maintenance. **Matron** (**1**) for Jan. 1. Salary: $250 per mo. less $45 maintenance. 30-bed hospital in Northwestern Ont. Separate nurses' residence. 1 mo. vacation with pay after 1 yr. service. Successful applicants reimbursed rail fare on completion of 1 yr. service. Apply J. L. Skillen, District General Hospital, Box 280, Dryden, Ont.

Night Supervisor for 320-bed Tuberculosis Hospital. Hours, 3:00 p.m.-11:00 p.m. Starting salary: $195 per mo. 44-hr. wk. 7 statutory holidays per yr. 3 wks. annual vacation. For further information apply Director of Nursing, Fort William Sanatorium, Fort William, Ont.

Public Health Nurse (qualified) for St. Catharines-Lincoln Health Unit by Jan. 1. Generalized program in urban & rural municipalities working from St. Catharines. Salary schedule: $2,000-2,500 plus Cost of Living Bonus. Blue Cross Hospital Plan & Physicians' Services Inc. available. Workmen's Compensation. Cumulative sick leave. 1 mo. holiday. Liberal transportation allowance. Excellent working conditions. Apply Miss W. V. Godard, Director, Public Health Nursing, St. Catharines-Lincoln Health Unit, St. Catharines, Ont.

Registered Nurses for General Duty for 50-bed hospital in town on Lake Ontario near Toronto. Salary: $170 per mo. with additional $10 for 4-12 duty. Apply Supt. of Nurses, General Hospital, Cobourg, Ont.

General Duty Nurses for 100-bed hospital. Salary & hours according to R.N.A.B.C. schedule. Apply, stating age & qualifications, to Supt. of Nurses, Nanaimo Hospital, Nanaimo, B.C.

Graduate Nurses urgently needed for hospital in Central San Joaquin Valley in Calif. Special services—Surgery, Obstetrics, Communicable Diseases, General Duty. Particulars furnished on request. Apply Director of Nurses, Kings County General Hospital, Hanford, California.

General Duty Nurses. Salary: $163.40 (one sixty-three dollars & forty cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Supt. of Nurses for 500-bed Class A, Toronto hospital with Training School of 150 students. Apply, stating qualifications, salary expected, etc., c/o Box G, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Science Instructor (**1**) **& Nursing Arts Instructor** (**1**) for new hospital to be opened 1952. Salaries open. Apply Supt., Charlotte County Hospital, St. Stephen, N.B.

Registered Nurses (**2**) **for General Duty** in new modern 20-bed hospital. Salary: $160 per mo. & full maintenance. Duties to commence Jan. 1. Apply P. J. Rasmussen, Sec., Union Hospital, Climax, Sask.

Registered Nurses for General Duty in 25-bed General Hospital. Salary: $140 per mo. plus full maintenance. 44-hr. wk. Apply Supt., Louise Marshall Hospital, Mt. Forest, Ont.

Public Health Nurses for Province of Alberta. Rural service. Emergency treatment, preventive & maternity program. Furnished cottage, fuel, water supplied. Salary schedule: $2,400-3,000. Sick leave, annual vacation, pension. Apply Director, Nursing Division, Dept. of Public Health, Edmonton, Alta.

Matron (bilingual preferred) for 20-bed modern Cottage Hospital, 20 miles from Ottawa, by Dec. 15. Salary: $175 plus full maintenance. Apply Gatineau Memorial Hospital, Wakefield, Que.

General Duty Nurses (**2**) (bilingual preferred) for 20-bed modern Cottage Hospital, 20 miles from Ottawa, by Dec. 15. Salary: $140 plus full maintenance. Apply Gatineau Memorial Hospital, Wakefield, Que.

Registered Nurses for General Duty for 35-bed General Hospital, 50 miles from Toronto. Gross salary: $178 per mo. 48-hr. wk., rotating shifts. 3 wks. annual vacation. 8 statutory holidays. For particulars apply Supt., Lord Dufferin Hospital, Orangeville, Ont.

Asst. Supervisor, Operating Room. Experience & post-graduate study preferred. Beginning salary not less than $167.50 plus 2 meals & laundry with additional recognition for graduate study & yrs. of experience. Annual increments, vacation & sick time on salary. **Science Instructor** for 1952-53. Experience with B.Sc. required. Begin. salary dependent on yrs. of experience & qualifications; monetary recognition for B.Sc. **Nursery Supervisor** with experience & p.g. study preferred. Begin. salary not less than $167.50 with 2 meals & laundry. Monetary recognition for grad. study. **General Duty Nurses.** Basic begin. salary: $147.50 plus 2 meals & laundry. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.